Audit Risk & Assurance Committee

Tue 18 July 2023, 09:30 - 11:30

Microsoft Teams

Agenda

1. Preliminary Matters

1.0 Audit_Risk & Assurance Committee Final Accounts Agenda.v2.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the Meeting held on 23 May 2023

Paper *Chair*

1.4 Draft ARAC Minutes 23rd May 2023 - IJ.pdf (7 pages)

1.5. Committee Action Log

Paper *Chair*

1.5 Draft Audit Risk Assurance Committee Action Log July 2023 - IJ.pdf (4 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. Ratify the Clinical Audit Plan 2023 – 2024

Paper *Assistant Director for Quality & Patient Safety*

2.1 Clinical Audit Plan ARA July 2023 Cover Report.pdf (6 pages)
2.1a Clinical Audit Plan ARA July 2023.pdf (24 pages)

3. ITEMS FOR DISCUSSION

3.1. Receive a Quarterly Report on Counter Fraud Activity including:

Paper *Director of Finance & Procurement*

- **Wales Thematic Engagement exercise "Risk Based Local Proactive Work" Report**
- **Confirmation of the Counter Fraud Functional Standard Return Declaration**

3.1 ARAC Counter Fraud Report Q1 23-24 .pdf (5 pages)
3.1a Appendix 1 RiskLPE.final.report.Wales overarching.TB.01-06-23 .pdf (16 pages)
3.1b Appendix 2 List of Reactive Cases.pdf (3 pages)
3.1c Appendix 3 CFFS ACC_DOF_HofCF Signed Declarartion.pdf (1 pages)

3.2. Receive the Internal & External Audit Recommendations Tracker

Paper *Director of Corporate Governance*

3.2 Internal_External Audit Recommendations 31 March 23 Cover Report ARAC.pdf (8 pages)
3.2a Appendix 1 Overdue Internal Audit Recommendations 31.03.23.pdf (7 pages)
3.2b Appendix 2 Complete Internal Audit Recommendations 31.03.23.pdf (5 pages)
3.2c Appendix 3 Overdue External Audit Recommendations 31.03.23.pdf (2 pages)
3.2d Appendix 4 Complete External Audit Recommendations 31.03.23.pdf (1 pages)

3.3. Receive the Internal Audit Progress Report

Paper *Deputy Head of Internal Audit*

3.3 ABUHB July 2023 Audit Committee Progress Report v2.pdf (10 pages)

3.4. Receive Assurance-Rated Reports

Paper *Deputy Head of Internal Audit*

3.4.1. Reasonable Assurance Rated

- Clinical Futures – Care Closer to Home
- Infection, Prevention, and Control
- Integrated Wellbeing Networks
- Dementia Services
- Contract Management

3.4.1a AB 2223-04 Clinical Futures - Care Closer to Home .pdf (9 pages)
3.4.1b AB 2223-11- Final IPC Internal Audit Report.pdf (12 pages)
3.4.1c AB 2223-15 - Final IWN Internal Audit Report for Client.pdf (13 pages)
3.4.1d ABUHB-2223-10 Dementia Services Final Report.pdf (28 pages)
3.4.1e ABUHB 22-23 Contract Management - Internal Audit FINAL Report For client v1.2.pdf (15 pages)

3.5. Receive the Annual Head of Internal Audit Opinion

Paper *Deputy Head of Internal Audit*

3.5 ABUHB FINAL Opinion Annual Report 22-23 for Client v2.pdf (36 pages)

3.6. Receive the External Audit Progress Report

Paper *Performance Audit Lead, Audit Wales*

3.6 Audit Risk and Assurance Committee Update - July 2023.pdf (12 pages)

3.7. Review of the Final Annual Report 2022/23, including:

Paper *Director of Corporate Governance*

a) Performance Report (Part 1)

b) Accountability Report (Part 2)

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability & Audit Report

3.7 ARAC Annual Report Cover Paper 2022.23.pdf (7 pages)
3.7 Attachment One comments ARAC and Audit Wales.pdf (6 pages)
3.7a FINAL DRAFT Performance Report 2023 12.07.23.pdf (43 pages)
3.7b FINAL DRAFT Accountability Report 2022.23 12.07.23.pdf (121 pages)

3.8. Review of the final Financial Statements 2022/23 (Part 3), including:

Paper *Director of Finance & Procurement*

- **Annual Accounts 2022/23**

3.8 ARA report on final 2022-23 Annual Accounts .pdf (4 pages)
3.8 Appendix 1 - adjustments actioned.pdf (2 pages)
3.8 Appendix 2 Voluntary Organisations.pdf (1 pages)
3.8.a ABUHB 2022-23 Final Annual Accounts.pdf (77 pages)

3.8.1. Receive the Audit of Accounts (ISA 260) including Letter of Representation

Paper *Finance Audit Manager, Audit Wales*

3.8.1 ABUHB Letter of Representation 2022-23.pdf (3 pages)
3.8.1 Draft ABUHB Audit Accounts Report 2022-23 12.07.23.pdf (28 pages)

3.9. Agree a recommendation to the Board in respect of the Audited Annual Report and Accounts

Oral *Chair*

4. ITEMS FOR INFORMATION

Oral *Chair*

No Items Received

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting:

Oral *Chair*

Tuesday 12th September 09:30 – 12:00

6. Close of Meeting

Oral *Chair*

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN** **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 18th July 2023 at 09:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 23 May 2023	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Ratify the Clinical Audit Plan 2023 – 2024	Attached	Assistant Director for Quality & Patient Safety
3	**ITEMS FOR DISCUSSION**		
3.1	Receive a Quarterly Report on Counter Fraud Activity including: • Wales Thematic Engagement exercise "Risk Based Local Proactive Work" Report • Confirmation of the Counter Fraud Functional Standard Return Declaration	Attached	Director of Finance & Procurement
3.2	Receive the Internal & External Audit Recommendations Tracker	Attached	Director of Corporate Governance
3.3	Receive the Internal Audit Progress Report	Attached	Interim Head of Internal Audit

3.4	Receive Assurance-Rated Reports **Reasonable Assurance** • Clinical Futures – Care Closer to Home • Infection, Prevention, and Control • Integrated Wellbeing Networks • Dementia Services • Contract Management • Mental Health Transformation	Attached	
3.5	Receive the Annual Head of Internal Audit Opinion	Attached	
3.6	Receive the External Audit Progress Report	Attached	Performance Audit Lead, Audit Wales
3.7	Review of the Final Annual Report 2022/23, including: a) Performance Report (Part 1) b) Accountability Report (Part 2) i. Corporate Governance Report ii. Remuneration and Staff Report iii. Parliamentary Accountability & Audit Report	Attached	Director of Corporate Governance
3.8	Review of the final Financial Statements 2022/23 (Part 3), including: a) Annual Accounts 2022/23	Attached	Director of Finance & Procurement
3.8b	Receive the Audit of Accounts (ISA 260) including Letter of Representation	Attached	Finance Audit Manager, Audit Wales
3.9	Agree a recommendation to the Board in respect of the audited annual report and accounts	Verbal	Chair
4	**ITEMS FOR INFORMATION**		
4.1	No Items Received	Attached	Chair
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair

5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • Business Meeting: Tuesday 12th September 09:30 – 12:00		

KEY:	
Priority 1	• Every Child has the Best Start in Life
Priority 2	• Getting it Right for Children and Young Adults
Priority 3	• Adults in Gwent Live Healthily and Age Well
Priority 4	• Older Adults are Supported to Live Well and Independently
Priority 5	• Dying Well as part of Life
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance

Motion to Exclude Members of the Public and the Press

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:
"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".
Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DATE OF MEETING	Tuesday 23rd May 2023
VENUE	Microsoft Teams

PRESENT	Iwan Jones- Independent Member, Committee Chair Paul Deneen- Independent Member Shelley Bosson- Independent Member Richard Clark- Independent Member
IN ATTENDANCE	Rob Holcombe- Director of Finance and Procurement Rani Dash- Director of Corporate Governance Mark Ross- Assistant Finance Director Stephen Chaney- Deputy Head of Internal Audit, NHS Wales Shared Services Partnership (NWSSP) Andrew Doughton- Audit Manager (Performance), Audit Wales Richard Harries- Audit Manager, Audit Wales Estelle Evans- Head of Financial Services and Accounting Bryony Codd- Head of Corporate Governance Emma Guscott, Committee Secretariat
APOLOGIES	Nicola Prygodzicz- Chief Executive

ARA 2305/1	**Preliminary Matters**
ARA 2305/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARA 2305/1.2	**Apologies for Absence** Apologies for absence were noted.
ARA 2305/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
ARA 2305/1.4	**Minutes of the previous meeting** The minutes of the meeting held on the 18th of April 2023 were agreed as a true and accurate record.

ARA 2305/1.5	**Committee Action Log** The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions. Shelley Bosson (SB), Independent Member highlighted the following two missed actions from the previous meeting: • ARAC1804/18- Reasonable Assurance- Robotic Process Automation: stronger evidence of benefit realisation would be required before expanding the RPA provision, a paper to be prepared for the next Finance and Performance Committee to provide more detail on the cost and benefit realisation. • ARAC1804/23- Audit Wales Orthopaedic National and Local Report and Management Response: An annual update report, based on the questions included in the local report, to be presented to PQSOC. Rani Dash (RD) agreed that an annual update report to PQSOC would be appropriate and would include it in the PQSOC work plan.
ARA 2305/2	**Items for Discussion**
ARA 2305/2.1	**Review of the Draft Annual Report 2022/23, including:** Rani Dash (RD), Director of Corporate Governance, provided an overview of the reports to the Committee. The draft reports had been submitted to Audit Wales and Welsh Government for comments. RD welcomed comments from members. **Performance Report (Part 1)-** Shelley Bosson (SB), Independent Member, queried the following: • Performance data under *Priority 3, Adults Living Healthily and Ageing Well, deteriorated (6.6% increase)* and d*eteriorated (4.7% increase),* SB requested comparative data be included. • No performance data included in two sections in *Priority 5, Dying Well as Part of Life.* RD informed members that the data was unavailable at the time of the draft but would be included in the final report. **Accountability Report (Part 2)** • **Corporate Governance Report** • **Remuneration and Staff Report**

	• **Parliamentary Accountability & Audit Report** SB requested consistency of job titles when referring to the Director of Corporate Governance. Iwan Jones (IJ), Committee Chair, highlighted the staffing numbers, noting an increase in administrative staff and a decrease in nursing staff. RD informed members that recruitment was monitored through the People and Culture Committee and included in the Workforce Performance Dashboard. A statement explaining recruitment numbers to be included in the final report. **Action: Director of Corporate Governance/Director of Workforce and OD** The Committee **NOTED** the reports.
ARA 2305/2.2	**Review of the Draft Financial Statements 2022/23 (Part 3), including: Annual Accounts 2022/23** Rob Holcombe (RH), Director of Finance and Procurement, supported by Mark Ross (MR), Assistant Finance Director, provided an overview of the report, highlighting current the position, key change issues and comparative data. Iwan Jones (IJ), Committee Chair, requested an update on the progress of the Audit Wales audit of accounts. MR informed members that progress was on track to meet the deadline of submission to Welsh Government by the 31st of July 2023. MR discussed the new Inflow system for collating and sharing information, and its positive impact on the audit process for both the Health Board and Audit Wales. Richard Harries (RHa), Audit Manager, Audit Wales, informed members that there were no concerns to flag and that the audit was on track. Paul Deneen (PD), Independent Member, discussed the following: • Noted the changes to the International Financial Reporting Standard 16 (IFRS 16), as outlined in the report, and queried what internal changes were required to adhere to the new statutory changes. RH discussed the changes, highlighting that there was now a requirement to record Health Board leases as an asset, through the capital finance arrangement. • In relation to the 9.6m decrease in expenditure for voluntary organisations; what impact did this have on voluntary organisations supporting the Health Board. MR informed members that previously

	funding was provided through the Health Board for those organisations, however they now received this funding directly. MR to provide further information to members outside of the meeting. **Action: Assistant Finance Director** IJ highlighted the statutory breach as outlined in the report and requested additional narrative of any potential impact because of the breach. RHa to work with RH on the narrative to support the statement. **Action: Director of Finance and Procurement/Audit Wales** Rani Dash (RD), Director of Corporate Governance, informed members that information on financial recovery was included in the Health Board's Annual Governance Statement. The Committee **RECEIVED** the report for **ASSURANCE**.
ARA 2305/2.3	**Audit Enquiries to those charged with Governance and Management** Mark Ross (MR), Assistant Finance Director, presented to report to the Committee. Members were informed that the report formed assurance as part of the audit process, supporting the auditors to provide an audit opinion on the financial statements for 2022-23. The report had been shared with Audit Wales. The Committee thanked the finance teams for their hard work. The Committee **RECEIVED** the report for **INFORMATION**.
ARA 2305/2.4	**Receive Internal Audit Progress Reports** Stephen Chaney (SC), Deputy Head of Internal Audit, NWSSP, provided an update the Committee. **Reasonable Assurance Rated Reviews:** **Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevil Hall Hospital -** SC provided an overview to members, noting that the RSC had commenced in January 2023. The RSC project remained aligned to schedule and budget, with key areas to work on, as outlined in the report.

	Royal Gwent Hospital Redevelopment & Expansion of Endoscopy Services- SC provided an overview to members. The project programme highlighted slippage of four weeks, with a potential slippage of twelve weeks, being assessed in line with contractual arrangements. An underspend of £139,000 was noted, arising from savings from non-works costs. Key areas of work were discussed, noting that the *receipt of project documentation for scrutiny* had since been actioned. Shelley Bosson (SB), Independent Member, raised concern over the similar recommendations on both audits of capital projects. SB queried if there were any noticeable themes around compliance of contract management, highlighting her concern around the governance of capital projects. Iwan Jones (IJ), Committee Chair, noted that the audit recommendations were the same as noted in previous development audits and that lessons had evidently not been learned. It was recommended that the audit actions were revisited and that these be escalated if appropriate to ensure recommendations were implemented. Rani Dash (RD), Director of Corporate Governance assured members that the governance around capital projects was overseen by the Partnerships, Population Health, and Planning Committee (PPHPC). An item on Capital Project governance reviews and revised arrangements would be presented at the meeting of the PPHPC, led by the Director of Strategy, Planning and Partnerships. **Action: Director of Strategy, Planning and Partnerships** The Committee **NOTED** the report.
ARA 2305/2.5	**Receive the Final Internal Audit Plan 2023/24** Stephen Chaney (SC), Deputy Head of Internal Audit, NWSSP, provided an update to the Committee. Members were informed that the remainder of the 2022/23 plan would be completed in the coming weeks. Progress had been made against plans for 2023/2024, noting that the Asset Management of Equipment and Medical Devices had now been separated into two separate audits based upon areas of responsibility, which will be picked up in quarter 3.

	SC informed members that the outcome for 2022/2023 internal audit was to issue a reasonable assurance overall opinion. The improvement in corporate governance arrangements was highlighted. Limited assurance reports were discussed, noting that there were six for 2022/2023, which was an increase on the previous year. SC informed members that positive improvements had been made in those areas. The Committee **NOTED** the report and thanked the NWSSP teams for their work.
ARA 2305/2.6	**Receive External Audit Progress Report** Richard Harries (RHa), Audit Manager, Audit Wales, supported by Andrew Doughton, Audit Manager, Audit Wales, provided an overview of the report to members. Members were assured that the Charitable Funds audits would meet statutory deadlines. Delays in some audit cycles were discussed, noting the impact of the new ISA 315, that came into effect from December 2021. The ISA 315 is a new auditing standard for compliance across auditing bodies, as outlined in the Audit Plan 2023/24. RHa gave special thanks to the Health Board's Finance team for their support and engagement. RHa welcomed discussions with the Health Board around a potential new deadline for future audits. **Action: Audit Wales/Director of Finance and Procurement**
ARA 2305/2.7	**Receive External Audit Plan 2023/24** *Richard Clark left the meeting.* Richard Harries (RHa), Audit Manager, Audit Wales, supported by Andrew Doughton, Audit Manager, Audit Wales, provided an overview of the report to members. The following was discussed: • Accounts: there would be a new targeted approach, under the new ISA 315, around areas of focus and potential risk. • Performance: there had been a deep dive into digital investment.

	• The audit fee had increased by approximately 15%. This fee was proposed under the ISA 315. A finalised figure would be provided to the Committee in July 2023. The Committee **NOTED** the report and thanked the Audit Wales team for their work.
ARA 2305/3	**Other Matters**
ARA 2305/3.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no matters arising.
ARA 2305/3.2	**Date of the next meeting; -** • Final Annual Accounts – Tuesday 18th July 2023 09:30 – 11:30 • Business Meeting – Tuesday 12th September 09:30 – 12:00

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Dec 2022	**AC0112/03** Consultant Job Planning	Following the implementation of the automated job planning process an update report is to be received at a future meeting to close off Audit Recommendations.	Secretariat / Medical Director	**08 February 2024**	**Not Due** Due to the Audit, Risk and Assurance Committee's 2023/24 schedule, an update has been scheduled for February 2024. This ensures enough time between implementation and progress to be reported. The People and Culture Committee will receive an update on progress at its meeting on, 18th October 2023.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2023	**ARAC1804/14** Strategic Risk & Assurance Report	An update on the new risk **CRR046 -** Reinforced Autoclaved Aerated Concrete (RAAC) within structures to be obtained from the Planning Team and circulated to Committee Members.	Director of Strategy, Planning and Partnerships	**23 May 2023**	**In progress.** The Director of Planning, Partnerships & Strategies advised that surveys are currently being finalised, with the outcomes being presented to Board in July.
April 2023	**ARAC1804/18** Reasonable Assurance- Robotic Process Automation:	Stronger evidence of benefit realisation would be required before expanding the RPA provision, a paper to be prepared for the next Finance and Performance Committee (F&P) to provide more detail on the cost and benefit realisation.	Chief Digital Officer / Secretariat	**21 June 2023**	**Completed.** Transferred action to the F&P Committee
April 2023	**ARAC1804/23** Audit Wales Orthopaedic National and Local Report and	An annual update report, based on the questions included in the local report, is to be presented to Patient Quality, Safety & Outcomes Committee (PQSOC).	Secretariat		**Completed.** The action has been transferred and added to the PQSOC work plan.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Management Response				
May 2023	**ARAC2305/2.1** Review of the Draft Annual Report 2022/23 Accountability Report	A statement to be added to the final Accountability Report explaining recruitment numbers.	Director of Corporate Governance /Director of Workforce and OD	**18 July 2023**	**Completed.** Included in the final report.
May 2023	**ARAC2305/2.2** Review of the Draft Financial Statements	More information on the decrease in expenditure for voluntary organisations and the impact on voluntary organisations that support the Health Board will be shared with Committee Members outside of the meeting.	Assistant Director of Finance	**09 June 2023**	**Completed.** Included in the final report.
May 2023	**ARAC2305/2.2** Review of the Draft Financial Statements	The Chair requested that additional narrative be added to the financial statement to address any potential	Director of Finance and Procurement /Audit Wales	**18 July 2023**	**Completed.** Included in the final report.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		consequences of the statutory breach.			
May 2023	**ARAC2305/2.4** Internal Audit Progress Reports	An item on Capital Project governance reviews and revised arrangements would be presented at the meeting of the Partnerships, Population Health, and Planning Committee (PPHPC)	Director of Strategy, Planning and Partnerships / Secretariat	**09 June 2023**	**Completed.** The action has been transferred and added to the PPPHPC work plan.
May 2023	**ARAC2305/2.6** External Audit Progress Report	Discuss the audit cycle and deadlines for future audits	Audit Wales / Director of Finance and Procurement	**18 July 2023**	**Completed.** This is discussed at quarterly meetings between Audit Wales and the Director of Finance and Procurement.

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.

Once the Committee is assured that an action is complete, it will be removed. This will be agreed upon at each Committee meeting.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 July 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Plan 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective are.

When conducted in accordance with best practice standards, clinical audit: provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guideline defined standards of care. It also improves the quality of care and patient outcomes.

The Health Board has Four Priorities:

- That there is scrutiny of national clinical audit performance at directorate and divisional level (overseen by the Clinical Effectiveness Committee) with robust development, monitoring, and completion of Improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risks identified from datix, complaints and outcomes of care.

- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

Cefndir / Background

Clinical audit is one tool in a wider quality improvement strategy aimed at providing assurance with respect to delivery of best practice care. National Clinical Audits are mandatory audits set out by Welsh Government which all health boards must participate in. Aneurin Bevan University Health Board complies with the requirements of Welsh Government by participating in all mandatory national clinical audits.

As suggested by the Healthcare Quality Improvement Partnership (HQIP), Aneurin Bevan University Health Board clinical audit team will update the following organisational documents, ensuring they are linked and read together to ensure the effective management of clinical audit:

- **Clinical Audit Policy** – the current Policy is being updated to reflect the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice, and improving the quality of services to meet the needs of patients, healthcare commissioners, healthcare regulators, and others.
- **Clinical Audit Strategy 2022-25** – The Clinical Audit Strategy sets out the principles of when clinical audit should be used. How an audit is identified as required and planned and how this links with the Quality Management System under development in ABUHB. It describes how the Health Board will implement the strategy, and increase the impact of audit on improvement in clinical services.
- **The clinical audit plan** has been developed for the next 24 months: this will provide a prioritised summary of planned clinical audit activity and outcomes, that is regularly updated and scrutinised in accordance with the above clinical audit policy and strategy.
- **A clinical audit report template** has been developed using the web-based Audit Management system (AMaT): this will provide consistency in clinical audit reporting and will allow completion of audit actions to be visible to the corporate and divisional team.

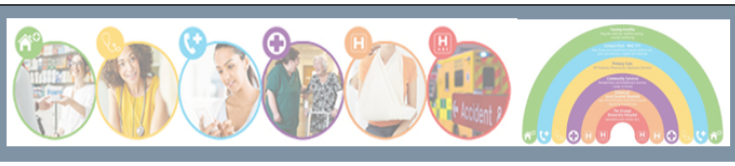
Our clinical audit plan will reflect national and local drivers for quality improvement. It will aim to balance key drivers with directorate/division/service/ clinician priorities. Using AMaT will ensure there is a system for prioritisation of clinical audit and enable monitoring to ensure clinical audits selected for the programme are completed.

Asesiad / Assessment

Development of 2023/24 Plan

In developing the Aneurin Bevan University Health Board audit plan the Clinical audit team has ensured the following has been considered:

- Ensuring that directorates participate in all national clinical audits, national confidential enquiries and service reviews relevant to the services that it provides.



- Participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).
- National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).
- Clinical audits identified or required for Board Assurance Framework.
- NICE guidance and HTW adoption. Audit is not mandatory but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Ensuring that all clinical audit activity within directorates is registered.
- Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).
- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required from clinical incidents, complaints or risks.

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by the Welsh Government (WG) annually. This plan is one of the foundation cornerstones in the drive to improve the quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of the healthcare provided to patients and to assess year on year improvements. The plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

The Health Board's clinical audit plan will be updated electronically and provide a list of all the clinical audit projects planned or undertaken. The nine-month publication schedule for the NCAPORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) will be shared with Directorates. This will be updated on a rolling month basis to ensure the nine months are captured within the plan. This will align with presentation of results at Clinical Standards and Effective Group (CSEG) and dates for Operational Groups and Outcome Committees. The Clinical Audit intranet page will host the publication list.

We are have engaged with Divisions to facilitate implementation of the Clinical Audit Strategy by presenting at meetings throughout January and February 2023. The Clinical Audit Plan will be shared after approval. The Clinical Leads and Divisional Triumvirate will be contacted ahead of the proposed date the reports will be issued. A link to the HQIP site will be available on the clinical audit intranet page. The clinical audit team will produce an annual audit report.

Clinical Audit for Assurance

Clinical audit is a quality improvement tool aimed at providing assurance on delivery of best practice. In its review of clinical audit, the Healthcare Quality Improvement Partnership (HQIP) suggested that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance the Clinical Audit Plan should meet external commitments and expectations and internal priorities. The Plan should be able to provide confirmation that clinical practice compares favourably with evidence of good practice but, where this is not the case, that changes are made to improve the delivery of care.

Improved communication and encouragement of audit

Audit results presented at CSEG will enable feeding back on the benchmarked performance of individual providers within clinical audits and reviews to organisations as appropriate for reflection and action. From April 2023 audit reports will be standardised using AMaT to ensure successes and challenges are documented and a detailed, CSEG agreed, action plan is visible on AMaT.

The regular publication of a National Clinical Audit and Outcome Review e-bulletin highlighting developments and findings from recent reports will be made available to clinicians via CSEG. The ambition of the clinical audit team is to raise the profile of clinical audit with boards, patient groups, clinicians and all staff working within the health board. AMaT is enabling closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.

The introduction of the web-based system AMaT (Audit Management and Tracking) will make auditing easier, faster, and more effective. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe. Using AMaT, Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data using a dashboard and easy-to-read graphical presentations. This will improve engagement with clinical directors, QPS audit team and CSEG.

ABUHB is in the process of training staff to use AMaT. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with relevant documentation uploaded and allocated an audit lead. The Clinical Lead is the audit lead for the specialty of the NCA. Defined objectives are identified and are time specific for the audit period. Local audits are being registered in the Clinical Audit area on AMaT.

AMaT will facilitate effective clinical audit and provide an oversight of audit data. This will improve accountability for clinical audits, visibility of action plans and allow tracking of actions, providing assurance to the Committee and Executive Board.

The National Clinical Audit and Outcome Review Plan is a mandated programme of national audit commissioned by the Health Quality Improvement Partnership. It is published by Welsh Government annually and confirms the list of NCAs that require mandatory participation by the Health Board. It specifies how findings from audits should be used to measure and drive forward improvements in healthcare in Wales. This will form part of the new Clinical Audit Plan. Our ambition is to ensure clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

The plan was presented and ratified by the Patient Quality and Safety Outcomes Committee on 20th June.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team to develop a clinical audit programme for the next 12-24 months.

Work is underway to implement the clinical audit strategy, update the Health Board policy on clinical audit, produce a clinical audit programme and produce an annual Health Board audit report. AMaT is being implemented. Engagement with Divisions on clinical audit is planned.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Clinical Audit is integral to the delivery of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse

Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to the Audit, Risk & Assurance Committee:	Patient Quality, Safety & Outcomes Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Clinical Standards and Effectiveness Group

Quality and Patient Safety

Clinical Audit Plan 2023/2024

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Appendices:

Introduction

The Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective care.

Clinical audit when conducted in accordance with best practice standards, provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guideline defined standards of care. It also improves the quality of care and patient outcomes.

Aneurin Bevan University Health Board has four priorities:

- To ensure scrutiny of national clinical audit performance at directorate and divisional level, overseen by the Clinical Standards and Effectiveness Group, to ensure development, monitoring, and completion of improvement plans.
- Divisions to identify clinical audits which provide scrutiny and assurance associated with quality and safety risks identified from Datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.
- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

This Clinical Audit Plan should be read in conjunction with other Health Board Policies, namely:

- 'Clinical Audit Policy' – describes the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice and improving the quality of services to meet the needs of patients, healthcare commissioners and healthcare regulators.

Clinical Audit Policy Issue 1.1.pdf

- 'Clinical Audit Strategy 2022-25' sets out the principles for when clinical audit should be used. How an audit is identified and planned and how this links with the Quality Management System under development in Aneurin Bevan University Health Board. It describes how the Health Board will implement the strategy, and increase the impact of audit on improvement in clinical services.

Clinical Audit Strategy 2022 - 2025.pdf

Together these documents demonstrate how clinical audit will be developed, delivered and outcomes put into practice through service improvement.

Clinical Audit

What is clinical audit?

Clinical Audit forms part of the system for improving standards of clinical practice.

Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Clinical audit takes place as part of a quality improvement cycle that measures the concordance of care delivery with agreed local or national guideline defined standards. Following an audit, areas for improvement are identified and implemented before being re-audited with the aim of improving reliability and outcomes of care.

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way. When clinical audit is conducted well it enables the quality of care to be reviewed objectively.

Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage.

Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice. Welsh Government supports Welsh NHS Bodies to deliver 'The Duty of Quality'. The duty of

quality, is part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and came into force on 1 April 2023.

This provides statutory guidance that aims to help organisations deliver high quality care through better decision making and planning to ensure better outcomes for people using health services. The Duty also encourages Value-Based health care by focusing on patient defined goals for care, to allow the Health Board to better meet patients' needs.

What is the audit cycle?

The diagram below sets out the steps involved in a complete audit cycle. When a clinical audit reveals the need for improvements to a service it is important that re-audit takes place following implementation of agreed changes. Sometimes it will take several re-audits to improve a service and "close the loop".

Figure One: The audit cycle

Principles of the clinical audit plan

In developing the Aneurin Bevan University Health Board audit plan the following principles have been considered:

Ensuring that directorates participate in all National Clinical Audits (NCAs), National Confidential Enquiries (NCEPOD) and service reviews relevant to the services that it provides.

National audits, which are not on NCAPOP, but which are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls).

Clinical audits identified or required for Board Assurance Framework.

NICE guidance and HTW adoption. Audit is not mandatory, but implementation and audit of NICE guidance can be subject to external review.

Projects requiring re-audit after changes in practice.

Ensuring that all clinical audit activity within directorates is registered.

Working with clinicians, service managers, divisional governance and quality managers as well as clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.

Ensure healthcare professionals are enabled to participate in clinical audit to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.

Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

Clinical Audit Plan

This clinical audit plan will be added to and refined over a two year cycle. It provides a prioritised list of planned clinical audit activity. This will be regularly updated and scrutinised in accordance with the principles above and in line with emerging insights obtained from review of complaints, concerns, SUI investigations and evolving clinical guidance.

In its review of clinical audit, the Healthcare Quality and Improvement Partnership (HQIP) suggests that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance a clinical audit plan should developed which provides confirmation that clinical practice compares favourably with external standards of good practice and where this is not the case, that changes are made to improve the delivery of care.

Aneurin Bevan University Health Board's clinical audit plan reflects national and local drivers for quality improvement. It aims to balance the requirement to undertake national audit with directorate/ division/ service/ clinician priorities. The audit plan will ensure that necessary resources, governance and organisational structures are in place to support engagement in audits, reviews and national registries included in the annual plan.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads have been asked to confirm their list of local audits. They have also been asked to identify any other projects relating to clinical priorities where audit work will support the improvement of patient care.

Audit Management and Tracking System (AMaT)

Audit completion will be tracked using a specialised audit management system (AMaT). Key benefits include facilitation of audit management, management of re-audits, and visibility of noncompliance and logging of areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced within a specified timeframe.

Creation and delivery of actions arising from audit are an opportunity to improve safety and patient experience. Use of AMaT will ensure there is a system for prioritisation of clinical audit and will enable monitoring and tracking of actions. AMaT will facilitate effective clinical audit reporting of audit data. As part of CSEG, Audit Leads will provide Audit reports, using a standardised template, which will include a summary of areas of practice that already meet guideline/audit standards and an action plan for areas requiring improvement that are specific, measurable, achievable, realistic and time bound so that their implementation can be tracked.

National Clinical Audits

Participation is mandatory in all National Clinical Audits (NCAs) (Appendix One). The list of NCAs is updated on a rolling nine-month programme and will be updated on the Quality and Patient Safety Clinical Audit Intranet Page monthly.

All (NCA's) reports will be discussed at Directorate and / or Divisional level. Results are presented to the Clinical Standards and Effectiveness Group (CSEG) held bi-monthly who oversee and agree audit action plans and monitoring of their completion.

Following the conclusion of data collection for an audit and subsequent publication of results a reporting template will be completed with collaboration between the Quality and Patient Safety (QPS) Clinical Audit Team and the Clinical Lead for the audit (Appendix Two). This will involve recording the results and actions directly onto AMaT and utilsiing the pre-populated proforma on the system and enable visualisation of the report.

The standardised clinical audit report template in AMaT is being tested to provide consistency in the reporting of clinical audit and will allow completion of audit actions to be visible to the corporate and divisional team. See Appendix Two.

Local Audits

Local audits will be registered with the QPS Clinical Audit Team by using the 'Local Audit Registration Form' (Appendix Three). They will be approved in advance of registration by the specialty Audit Lead and Audit Facilitator, Lead Participant and Audit Mentor if Applicable.

The Divisional Management Triumvirate will be informed of Directorate audits being undertaken. The QPS Clinical Audit Team will ensure that all processes are carried out and completed.

Local audits must be registered via AMaT using the Local Audit Registration and sent to the QPS Clinical Audit Team via the email that is supplied on the form. This will allow organisational oversight of the results of all audit activity.

The current list of local audits that have been registered in AMaT can be seen in Appendix Four. This will be updated as AMaT training continues throughout the Health Board and whilst Divisions are switching to registering audits electronically.

The National Clinical Audit and Outcome Review Plan (NCAORP)

The annual National Clinical Audit and Outcome Review Plan (NCAORP) sets out the list of National Clinical Audits and Outcome Reviews which all health boards are expected to participate in each year.

The agreed NHS Wales programme of audits includes audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the Healthcare Quality Improvement Programme (HQIP).

The Health Board's clinical audit plan provides a list of all the clinical audit projects planned or undertaken.

This will be updated monthly to ensure the rolling nine-month NCAORP is reflected in the plan. Appendix One lists NCAs and CORP for 2023. The scheduling function on AMaT will align reporting with CSEG meetings and include dates for Operational Groups and Outcome Committees. This will be evaluated after six months.

NCAORP is published by the Welsh Government (WG) annually. This plan is one of the cornerstones in the drive to improve the quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements. The plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The objectives of NCEPOD are to assist in maintaining and improving standards of healthcare by undertaking confidential reviews of patient care and publishing national recommendations.

NCEPOD invites individuals/organisations to propose future studies and once agreed these studies are implemented nationally. See Appendix Five for Proforma that needs to be completed by the QPS Clinical Audit Team and the Division Triumvirate.

Appendix One – National Clinical Audit and Outcome Review Plan

This is published on a rolling nine-month programme and will be updated monthly on the Quality and Patient Safety Clinical Audit Intranet Page.

National Clinical Audit and Patient Outcomes Programme (NCAPOP) commissioned by Healthcare Quality Improvement Partnership (HQIP) and NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). Publication notification date 12th April 2023 –All the NCA's will be management in AMaT using the Clinical Area.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
373	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme (Data only) Oct-Dec 2022	NCA	Kings College London	Wed 12/04/2023	N/A
377	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation Report	NCA	Royal College of Surgeons	Wed 12/04/2023	25/5/23
387	NDA - National Diabetes Audit	National Diabetes Audit (Data only) Q3 data - Core & Diabetes Prevention Programme, DPP (Non-Diabetic Hyperglycaemia, NDH)	NCA	NHS Digital	Wed 12/04/2023	Invite to July CSEG
400	NVR - National Vascular Registry	National Vascular Registry Short Report: Impact of the Covid-19 pandemic on the provision of vascular surgery in the UK	NCA	Royal College of Surgeons	Thu 11/05/2023	Annual report presented Jan 2023

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
		National Health Service - March 2023 update				
246	NDA - National Diabetes Audit	National Diabetes Audit Core: Report 2 Complications and Mortality	NCA	NHS Digital	Thu 08/06/2023	Invited to July CSEG
396	GI-NBoCA - Gastro-Intestinal Cancer Audit Programme - National Bowel Cancer Audit	National Bowel Cancer Audit Short Report: Capturing transfer of bowel cancer patients from theatre to critical care in linked national clinical datasets	NCA	Royal College of Surgeons	Thu 08/06/2023	Will be invited to Sept 2023 CSEG.
401	GI-NOGCA - Gastro-Intestinal Cancer Audit Programme - National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit Short Report -"Socioeconomic differences in the impact of OG cancer on life expectancy"	NCA	Royal College of Surgeons	Thu 08/06/2023	Yet to present annual report - Will be invited to Sept 2023 CSEG.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
417	Child Health Clinical Outcome Review Programme	Transition from paediatric to adult services (cohort 1 October 2019 and 31 March 2021)	CORP	National Confidential Enquiry into Patient Outcome and Death	Thu 08/06/2023	N/A as did not complete the study.
262	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Admissions report	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023	Will be invited to Sept 2023 CSEG.
385	NDA - National Diabetes Audit	National Diabetes Audit Core State of the Nation report (Y1) - Care Processes and Treatment Targets 2021-2022	NCA	Royal College of Obstetricians and Gynaecologists	Thu 13/07/2023	Will be invited to Sept 2023 CSEG.
380	NACEL - National Care at the End-of-Life Audit	National Care at the End-of-Life Audit Annual Report	NCA	Royal College of Surgeons	Thu 13/07/2023	Discussed at EOLB.
404	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - trauma	N/A	University of Bristol	Thu 13/07/2023	For Division
416	Medical and Surgical Clinical Outcome	Medical and Surgical Clinical Outcome Review Programme Crohn's disease	CORP	National Confidential Enquiry into	Thu 13/07/2023	For Division

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
	Review Programme			Patient Outcome and Death		
420	Ep12 - National Audit of Seizures and Epilepsies	Epilepsy12 state of the nation report (cohort 2020-22)	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023	Not participating
388	NDA - National Diabetes Audit	National Diabetes Audit Type 1 State of the Nation report (Y1) 2021-2022	NCA	NHS Digital	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
389	NDA - National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (Y1)	NCA	NHS Digital	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
403	NAD - National Dementia Audit	National Dementia Audit National Report 2023	NCA	Royal College of Psychiatrists	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.
418	NPCA - National Prostate Cancer Audit	National Prostate Cancer Audit Short Report - Utilisation of the Rapid Cancer Registry Data in the NPCA and how to report this data (topic TBC)	NCA	Royal College of Surgeons	Thu 10/08/2023	Will be invited to Sept 2023 CSEG.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
412	FFFAP - Falls & Fragility Fracture Audit	National Hip Fracture Database (NHFD) State of the Nation 2023 report	NCA	Royal College of Physicians	Thu 14/09/2023	Will be invited to Nov 2023 CSEG.
407	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit (NEIAA) State of Nation Annual Report	NCA	British Society for Rheumatology	Thu 12/10/2023	Will be invited to Nov 2023 CSEG.
409	NDA - National Diabetes Audit	National Pregnancy in Diabetes (NPID) State of the Nation report	NCA	NHS Digital	Thu 12/10/2023	Will be invited to Nov 2023 CSEG.
421	MNI - Maternal, Newborn and Infant CORP	Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal surveillance (cohort 2020-22)	CORP	University of Oxford	Thu 12/10/2023	For Division
398	NVR - National Vascular Registry	National Vascular Registry 2023 Annual Report	NCA	Royal College of Surgeons	Thu 09/11/2023	Will be invited to Jan 2024 CSEG.
408	SSNAP - Sentinel Stroke	Sentinel Stroke National Audit Programme (SSNAP) State of the Nation Annual Report 2023	NCA	Kings College London	Thu 09/11/2023	N/A
415	FFFAP - Falls & Fragility Fracture Audit	National Audit of Inpatient Falls (NAIF) 2023 Annual Report	NCA	Royal College of Physicians	Thu 09/11/2023	N/A

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
423	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme maternal mortality surveillance (cohort 2020-22)	CORP	University of Oxford	Thu 09/11/2023	For Division
424	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme maternal mortality confidential enquiry (cohort TBC)	CORP	University of Oxford	Thu 09/11/2023	For Division
405	NCMD - National Child Mortality Database	National Child Mortality Database Thematic report - infection	N/A	University of Bristol	Thu 14/12/2023	For Division
422	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme MNI Perinatal confidential enquiry (cohort TBC)	CORP	University of Oxford	Thu 14/12/2023	For Division

Further audits added as of 11/05/2023

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Projected publication date - subject to change	Date to present at CSEG
426	PICANet - Paediatric Intensive Care Audit	Paediatric Intensive Care Audit State of the Nation Report (Jan-Dec 2022)	NCA	University of Leeds	Thu 14/12/2023	Will be invited to Jan 2024 CSEG.
427	NDA - National Diabetes Audit	National Diabetes Audit Core underlying data, 01/01/2022-31/03/2023, Eng & Wal	NCA	NHS Digital	Thu 14/12/2023	Will be invited to Jan 2024 CSEG.
406	NOA - National Obesity Audit	National Obesity Audit Preliminary Report (cohort TBC)	NCA	NHS Digital	Thu 11/01/2024	N/A
419	FFFAP - Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLSDB) 2024 State of the nation report (cohort TBC)	NCA	Royal College of Physicians	Thu 11/01/2024	Will be invited to Mar 2024 CSEG.
410	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Alcohol and Drug report (cohort TBC)	CORP	University of Manchester	Thu 08/02/2024	Will be invited to Mar 2024 CSEG.
411	NCISH - Mental Health CORP	Mental Health Clinical Outcome Review Programme Annual Report 2024 (cohort TBC)	CORP	University of Manchester	Thu 08/02/2024	Will be invited to Mar 2024 CSEG.

CLINICAL STANDARDS & EFFECTIVENESS GROUP (CSEG)

Appendix Two – Standardised Audit Reporting Template

ALL National Clinical Audit (NCA) results will be added to AMaT and presented at CSEG. Completion of an action plan is essential.
When making your action plan, ensure objectives are SMART: Specific, Measurable, Assignable, Realistic, Time-related.

Standardised template below, data added to AMaT and will be printed as a report

Project Details	
Title	Date registered:
Speciality:	Date at CSEG:
Division:	
Lead Participant:	Audit Lead:
Rationale:	Guidance:
Objectives:	

Project progress

- **Results**
- **Conclusions**
- **Assurance & risk**
- **Key successes & concerns**
- **Action plan**
- **Re-audit**

Appendix Three – Local Audit Registration Template

LOCAL AUDIT REGISTRATION

All audits to be entered onto AMaT (Audit Management and Tracking)

To be completed by ALL Divisions

Title of audit	
Date of application:	
Is this a re-audit?	Yes/No
Which area will be used for this audit?	**Clinical Area**
	Ward Area
Specialty Audit Lead: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Specialty Audit Facilitator: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Lead Participant: (Required in both Clinical and Ward Areas)	
Name:	
Designation:	
E-mail:	

Audit Mentor: (Clinical Area Only)	
Name:	
Designation:	
E-mail:	

Division:	
Specialty(s):	
Division approval granted	Yes/No
Approving name:	
Approving designation:	
Will the audit subject cross over into another division?	Yes/No
If yes, which other Division?	
Is the above Division signed up to the audit?	Yes/No
Rationale for the audit:	

Please identify which of the following best fits your application: (Yes/No)	
Project in relation to Health Board Objectives/risk/incident/NICE	Yes/No
If above is Yes, please detail:	
Divisional priority	Yes/No
Individual (specialty) Priority	Yes/No
Individual (CPD) Priority	Yes/No
Other:	
Project Planning	
Will a proforma be required in AMaT to collect the data?	Yes/No
If no, which professional body will be collecting the data?	
Is support from the QPS Team required:	Yes/No
If Yes, please e-mail: abb.clinicalaudit@wales.nhs.uk	
PLEASE ENSURE A SIGNED COMPLETED COPY OF THIS FORM IS E-MAILED TO THE ABOVE CLINCIAL AUDIT ADDRESS	

Appendix Four – Local Audit Plan

Currently there are 38 local audits registered in the AMaT Ward Registration Area for 2023/2024. Once the audits have been undertaken, they are available in a results table (see below), by audit frequency with the overall audit score. In the insight dashboard each question within the audit can be looked at the view the question score.

Results (table)

Label	Division	Business Unit	Speciality	Ward	Project	Audit	Submissions	Result
ABUHB - PVC Bundles Compliance Audit Tool - 01 Jan 2023 to 31 Jan 2023	Medicine	General Medicine	Care of the Elderly (COTE) (archived), Medicine	3/2 Usk Ward - NHH, Acute Medical Ward - RGH	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	11	36.4%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Feb 2023 to 28 Feb 2023	Family and Therapies, Medicine, Primary Care and Community, Scheduled Care	Family and Therapies, General Medicine, General Surgery, Primary Care	Care of the Elderly (COTE) (archived), ENT, Family & Therapies, Gastroenterology, Medicine, Primary Care, Respiratory Medicine, Stroke/Rehabilitation (USC)	3/3 Duffryn Ward - NHH, 3/4 Tretower Ward - NHH, 4/2 Crickhowell Ward - NHH, 4/4 Llanellen Ward - NHH, A/3 Ward - GUH, A/4 Ward - GUH, C/0 Ward - GUH, C/4 Ward - GUH, Medical Assessment Unit - GUH, Sirhowy Ward - YAB, Tyleri Ward - YAB	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	41	72.0%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Mar 2023 to 31 Mar 2023	Medicine, Scheduled Care	General Medicine, General Surgery	General Surgery, Medicine	C6 East Ward - RGH, D3 East Ward - RGH, D3 West Ward - RGH	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	12	83.3%
ABUHB - PVC Bundles Compliance Audit Tool - 01 Apr 2023 to 30 Apr 2023	Medicine, Primary Care and Community	General Medicine, Primary Care	Cardiology, Medicine, Primary Care	A/1 Ward - GUH, A/2 Ward - GUH, C6 West Ward - RGH, D4 East Ward - RGH, Ruperra Ward - SW	IPC Annual Audits	ABUHB - PVC Bundles Compliance Audit Tool	22	70.5%

The tables below identify the number of wards within a specialty that the audit has been registered to. For example, PVC Bundles audit is registered on 6 Acute Care wards. The audit has been registered to 138 wards across ABUHB.

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Annual	**24**	**48**	**10**	**4**	**20**	**170**	**85**	**4**	**37**	**2**	**4**	**7**	**12**	**4**	**36**	**24**	**13**	**8**	**4**	**8**	**10**	**16**	**550**
ABUHB - PVC Bundles Compliance Audit Tool	6	12	3	1	6	42	21	1	10		1	1	3	1	9	6	3	2	1	2	3	4	**138**
All Wales Adult Mouth Care Assessment Audit	6	12	2	1	4	39	21	1	9		1	1	3	1	9	6	3	2	1	2	2	4	**130**
Health & Safety Inspection: Respiratory Protective Equipment (RPE)	6	12	3	1	6	43	21	1	9	2	1	3	3	1	9	6	4	2	1	2	2	4	**142**
Provision of Snacks and Beverages						6	1					1									1		**9**
Treatment Escalation Plan	6	12	2	1	4	39	21	1	9		1	1	3	1	9	6	3	2	1	2	2	4	**130**
Weekly Stroke Thrombolysis Audit						1																	**1**
Grand Total	24	48	10	4	20	170	85	4	37	2	4	7	12	4	36	24	13	8	4	8	10	16	**550**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Quarterly	**6**	**12**	**3**	**1**	**6**	**51**	**33**	**1**	**12**	**1**	**26**	**9**	**2**	**9**	**6**	**4**	**2**	**7**	**2**	**3**	**18**	**214**
ABUHB - IPAC - Theatre Audit - Section 4 - Anaesthetic Rooms						3	3		2		4	1	1			1		1			3	**19**
ABUHB - IPAC - Theatre Audit - Section 5 - Theatre							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 6 - Scrub Room							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 7 - Dirty Utility / Sluice							1				4	1						1			1	**8**
ABUHB - IPAC - Theatre Audit - Section 8 - Recovery / Resuscitation							1				3	1						1			1	**7**
ABUHB - IPAC - Theatre Audit - Section 9 - Dirty Utility (Recovery)							1				3	1						1			1	**7**
ABUHB - IPAC- CAUTI Bundle Compliance Audit	6	12	3	1	6	42	21	1	10	1	1	3	1	9	6	3	2	1	2	3	4	**138**
ABUHB - IPS - Decontamination Dashboard (Scopes) (Urology & Endoscopy)						4	2				1										4	**11**
ABUHB - IPS - Endoscopy - Decontamination						2	2				2										2	**8**
Grand Total	6	12	3	1	6	51	33	1	12	1	26	9	2	9	6	4	2	7	2	3	18	**214**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Pathology	Primary Care	Radiology	Rheumatology	Sexual and Reproductive Health	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Monthly	**112**	**192**	**56**	**30**	**96**	**726**	**346**	**24**	**160**	**16**	**24**	**156**	**48**	**16**	**146**	**12**	**96**	**62**	**32**	**12**	**16**	**32**	**50**	**64**	**2524**
ABUHB - IPAC - (IPS) - Isolation Precautions	16	24	8	4	12	90	42	4	20	4	4	28	6	2	18	2	12	8	4	2	2	4	6	8	**330**
ABUHB - IPAC - Hand Hygiene Audit	16	24	8	4	12	90	42	2	20	4	4	22	6	2	18	2	12	8	4		2	4	6	8	**320**
ABUHB - IPAC - HCAI Audit - (Covid-19)	12	24	6	4	12	86	42	2	20		2	18	6	2	18	2	12	8	4		2	4	6	8	**300**
ABUHB - IPAC - HOUDINI Audit Tool	16	24	8	4	12	98	46	4	20	4	4	32	6	2	18	2	12	8	4	4	2	4	6	8	**348**
ABUHB - IPAC - Infection Prevention Quality Dashboards	16	24	8	4	12	98	46	6	20	4	4	36	6	2	20	2	12	8	4	6	2	4	6	8	**358**
ABUHB - IPAC - PVC Bundle Compliance Audit	12	24	6	2	12	84	42	2	20		2	6	6	2	18		12	6	4		2	4	6	8	**280**
Dignity and Essential Care Inspection (DECi) - Inpatient Care	12	24	6	4	12	84	42	2	20		2	6	6	2	18		12	8	4		2	4	6	8	**284**
Dignity and Essentials Care Inspection (DECI) - Ward Area	12	24	6	4	12	84	42	2	20		2	6	6	2	18		12	8	4		2	4	6	8	**284**
Malnutrition Screening for Inpatients (Updated)						12	2					2											2		**18**
Prothrombin Complex Concentrate use in ABUHB																2									**2**
Grand Total	112	192	56	30	96	726	346	24	160	16	24	156	48	16	146	12	96	62	32	12	16	32	50	64	**2524**

Audit Name and Frequency	Acute Care	CAMHS	Child Health	Critical Care and Resus	Family and Therapies	General Medicine	General Surgery	Gynaecology	Maternity	Mental Health and Learning Disabilities	Miscellaneous	Ophthalmology	Oral Surgery and Maxillo Facial	Outpatients	Pathology	Primary Care	Radiology	Rheumatology	Theatres	Therapies	Trauma and Orthopaedics	Urology	Grand Total
Weekly	**30**	**12**	**18**	**12**	**30**	**240**	**120**	**6**	**60**	**6**	**12**	**18**	**6**	**54**	**1**	**18**	**24**	**12**	**6**	**6**	**12**	**24**	**727**
2222/Cardiac Arrest Audit	30	12	18	12	30	240	120	6	60	6	12	18	6	54		18	24	12	6	6	12	24	**726**
Prothrombin Complex Concentrate use in ABUHB															1								**1**
Grand Total	30	12	18	12	30	240	120	6	60	6	12	18	6	54	1	18	24	12	6	6	12	24	**727**

AMaT training is currently underway to register local audits on AMaT, build a proforma, collect results and develop action plans.

The current list of local audits registered for April 2023

Division	Project type	Title
Family and Therapies	Clinical Audit Project	Adherence of appropriate investigations and counselling for women with POI
Family and Therapies	Service Evaluation	An evaluation of emergency contraception provision within ABUHB
Family and Therapies	Clinical Audit Project	BASHH (British Society of Sexual health and HIV) National Clinical Audit 2022: management of Mycoplasma genitalium (Mgen)
Family and Therapies	Clinical Audit Project	Menopause counselling in women undergoing bilateral salpingo-oophorectomy +/- hysterectomy before the age of 45
Clinical Support Services	Quality Improvement Project	An audit of the management of Staphylococcus aureus bacteraemia
Scheduled Care	Staff Questionnaire (feedback, satisfaction, etc.)	ICU nurses' decision-making around measuring gastric residuals to guide enteral feeding
Scheduled Care	Clinical Audit Project	The effect of oral anticoagulant use on surgical delay and mortality in older hip and femoral fracture patients
Corporate QPS	Peer review and Clinical Audit Project	Local Review Consent to Examination & Treatment Standards in Aneurin Bevan University Health Board

The local audit plan will be updated every six months as Directorates continue to add local audits on AMaT.

Appendix Five - National Confidential Enquiry into Patient Outcome and Death

Improving the quality of healthcare

National Confidential Enquiry into Patient Outcome and Death

ANEURIN BEVAN UNIVERSITY HEALTH BOARD NCEPOD PROCESSES

Name of Study:			
Date of initial correspondence from NCEPOD		Has inclusion specifics been provided?	Yes/No
Date NCEPOD request data returned?		Date inclusion specifics sent to informatics:	
Date Division informed of pending study:			

Has a Clinical Lead been requested by QPS?	Yes/No	Name of Clinical Lead:	

Date data returned from informatics:		Date data sent to NCEPOD: (via secure portal)	
Date added to NCEPOD platform:			

Is there and Organisational Questionnaire	Yes/No	How many OQ? (Site dependant)	
Deadline for OQ(s):			
Are there Clinical Questionnaires?	Yes/No	How many CQ? (No. of patients in study)	
Deadline for CQs:			

Have all patients been allocated to a clinician?	Yes/No	By whom in QPS CAT?	
Date allocated to a clinician:		Has the Division and CL been informed?	Yes/No
Once a CQ has been completed by a clinician, this triggers and email to the QPS CAT who will collect relevant case notes and submit to NCEPOD via the secure portal			
Comments:			

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 July 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Progress Quarter 1 Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance and Procurement
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Morris – Head of Counter Fraud

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A situation report has been prepared for the Aneurin Bevan University Health Board's Audit, Risk and Assurance Committee. It highlights the Counter Fraud work which has been undertaken by the Local Counter Fraud Specialist (LCFS) to date during financial year 2023/24.

Cefndir / Background

This document has been prepared by the Aneurin Bevan University Health Board Counter Fraud Team to comply with the legal directions and the NHS requirements of the Government Functional Standards S013.

Asesiad / Assessment

1 Counter Fraud Staffing

In relation to staffing the department has found itself one accredited LCFS down due to the individual having left the Health Board for promotion to a Lead role in Powys Teaching Health Board. This has resulted in the only currently accredited and qualified LCFS being the Head of Counter Fraud.

The other trainee LCFS who was appointed last October will complete her formal training and attain her accreditation in the autumn. This has resulted in reduced staffing capacity to some extent during Q.1 of this year.

A recruitment drive took place in early June and the interviews for the post for the LCFS took place on the 23rdJune 2023. Following, a new LCFS has been offered the post with a proposed commencement date of 1st August 2023. The new appointee is already an accredited LCFS currently working for Cardiff & Vale University Health Board so there will be no immediate training and/or development requirements.

2 Staff awareness

During this time the Counter Fraud Department has completed two lunch and learn sessions. One in relation to Hospital Pharmacy that specifically covered Management of Controlled Drugs and WP10 (Hospital Prescriptions). The other was in relation to Mandate Frauds and was geared towards Finance Staff. The Mandate Fraud awareness session was attended by 49 members of Aneurin Bevan University Health Board staff.

It appears that the fraud awareness programme undertaken by the LCFS is reaching its target audience and all mediums are being promoted to actively encourage fraud referrals. Thirteen such referrals have been received during Q1, with one of these referrals involved several members of staff. These referrals have been received via the NHS Fraud and Corruption reporting line, anonymously directly to ABUHB and directly to the LCFS via staff reporting. So far, these referrals together with another that was reported in February has resulted in four members of staff being interviewed under caution in the last quarter.

In Aneurin Bevan University Health Board, Counter Fraud awareness input at Corporate Induction and the fraud awareness e-learning programmes remain mandatory requirements. Financial year to date, 289 members of staff have completed Corporate Induction which includes the fraud awareness input. The new Counter Fraud E-Learning programme via ESR that went live on the 20th April 2023 has so far had 13 members of staff that have completed it.

3 Proactive Work

In Q1 of this financial year there has been a significant increase in the number of fraud referrals made and investigated. This together with the reduced staffing has meant there has been an impact on the LCFS undertaking any specific Local Proactive Exercises (LPE) or Fraud Risk

Assessment (FRA) work; other than to continue to engage with the NFI process. This will be rectified as soon as staffing levels are back to normal.

Fraud prevention activity

The LCFS has actioned the following alerts during Q1.

All Wales Alert notice – To all GP and Pharmacies. This notice was specifically to notify patients who were being cold called by fraudsters purporting to be from their GP practice/Pharmacies asking for payments in relation to services or drugs. Several elderly patients had paid over money, so it was decided that an all-Wales fraud alert was required even though there was no actual loss to the NHS.

National Fraud Initiative

The NFI commenced again in October 2022. All new Aneurin Bevan University Health Board users to the NFI will be required to attend online Cabinet Office training before commencement. To date there have been several cases where assistance has been provided to other organisations with the cross matching of subjects. The NFI work is well underway and from June 2023 the Counter Fraud Administrative Assistant will be provided with refresher training and working on the NFI matches full time for the next quarter at least.

Risk Based Local Proactive Work (Thematic Engagement Exercise)

On the 6th June 2023 the results of the NHS Counter Fraud Authority Risk Based Local Proactive Work (Thematic Engagement Exercise) were published and reported to each of the Health Boards in Wales. The report showed that Aneurin Bevan University Health Board along with Welsh Ambulance Service NHS Trust were the only Public Organisations that met the required standards at that time. Aneurin Bevan University Health Board were advised to continue to develop their Fraud Risk Assessments (FRA) during their reviews and Fraud Prevention Notices (FPN) should be actioned and recorded which was the case at the time.

The full report is detailed at **Appendix 1**.

In the next quarter it is hoped to revamp the current process of recording Risk Based Local Proactive Work and to engage more with Internal Audit to suggest areas of concern that could be further investigated.

4 Reactive Work

A list of current investigations is as detailed in **Appendix 2**. As stated above there has been 13 new referrals this Q1.

5	**Counter Fraud Functional Standard Return (2022-23)** The returns were completed and presented for signing off before the ARAC Chair and the Director of Finance and Procurement in May 2023. The final document was then submitted on the 23rd May 2023 to the NHS Counter Fraud Authority. A copy of the declarations of the ARAC Chair, the Director of Finance and the Head of Counter Fraud are attached at **Appendix 3.**
Argymhelliad / Recommendation This report is intended for Audit, Risk and Assurance Committee's information and views.	

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk Based Local Proactive Work (Thematic Engagement Exercise) Report. Copy attached.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The protection of the Health Board's finances are integral to delivery of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained throughout the report.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

APPENDIX 1

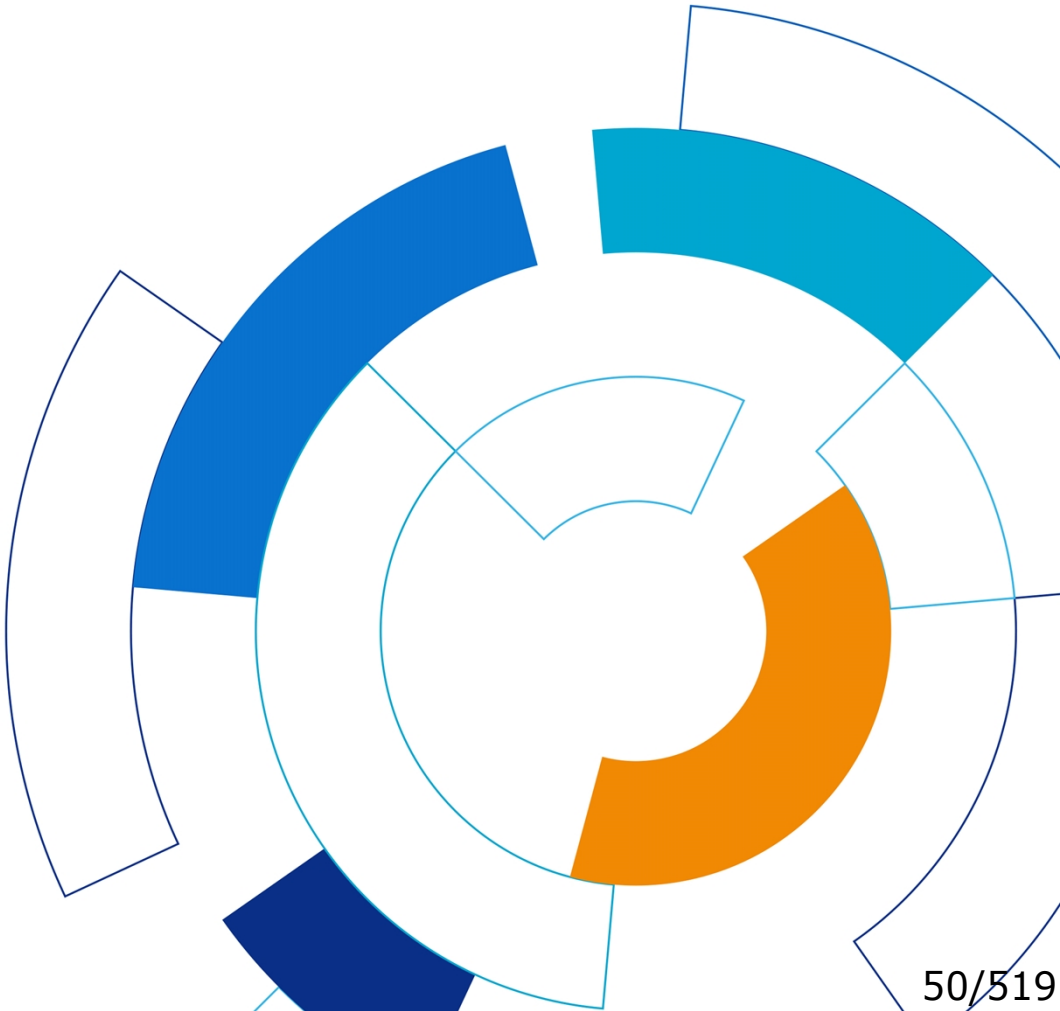
NHS Counter Fraud Authority

RISK BASED LOCAL PROACTIVE WORK

Thematic Engagement Exercise

JUNE 2023

Version 1.0 Final version



NHS fraud.
Spot it. Report it.
Together we stop it.

Version control

Version	Name	Date	Comment
0.1	T Barlow	30 May 2023	Initial draft
0.2	J Gall	01 June 2023	Proof read and comment
1.0	T Barlow	01 June 2023	Final

Contents

Executive summary

Background

Since April 2021 all NHS funded services have been required to provide assurance against the Government Functional Standard GovS 013: Counter Fraud. To enable NHS funded services to meet the Government Functional Standard the NHSCFA released a suite of NHS Requirements in January 2021.

The NHS Counter Fraud Authority (NHSCFA) describe the requirements for these counter fraud arrangements in a set of fraud, bribery, and corruption requirements within the Functional Standard, which are published annually for both NHS funded organisations and commissioners. Welsh Government has adopted the same stance and the NHS Counter Fraud Service Wales supports compliance with the NHS Requirements.

The NHS Requirements include in component 3 the need to undertake detailed local fraud risk assessments in line with the Government Counter Fraud Profession (GCFP) standards and methodology. Furthermore, the component requires health bodies to record and manage those risk assessments in line with their own risk management policies.

The NHS Requirements include in component 6 the need to identify and report on outcome-based metrics, informed by national and local risk assessment. The outcomes to be recorded on the approved NHS case management system.

The NHS Requirements include in component 8 the need to use the case management system to record all fraud, bribery, and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during investigations and/or proactive prevention and detection exercises.

The NHS Requirements include in component 10 the need to undertake proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption.

There is a requirement for the NHSCFA to seek assurance of compliance with these requirements from the sector and this thematic exercise will feed into the assurances sought. The findings will in turn inform future fraud landscape reports produced by the department.

Summary of findings

Firstly, we would like to thank those involved in the fraud risk assessment work and local proactive exercise (LPE) work undertaken to date and we have been encouraged by the progress made. Fraud risk assessment underpins how organisations can strategically counter fraud and more importantly at a local level ensure they have appropriate resources in place to mitigate fraud risk.

It was evident that in most cases organisations with the support of their counter fraud service provider had grasped the concepts of local fraud risk assessments and the process for conducting and recording local proactive exercises along with linking associated outcomes resulting from that work and this was encouraging.

It was pleasing that some LCFSs had worked closely with key staff at a local level to help support fraud risk work and some examples of how working closely with risk managers had expedited the fraud risk assessment process. It should however be noted that not all health boards had embraced the fraud risk assessment process and in some cases were in breach of their own policies as well as the NHS Requirements. This is reflected in both this general overarching recommendations made in this report and, in the organisation specific reports issued directly to those organisations included in the thematic exercise.

All health boards and trusts in Wales were covered in the exercise and face to face meetings were held with the LCFS leads responsible for the counter fraud provision. We would like to thank those LCFS leads for their professionalism in their approach to the exercise and their honesty of the position their organisation were in with fraud risk assessment and LPEs at the time of the exercise. We appreciate that progress will continue to be made in this area of counter fraud work and it may well be prudent to revisit the position in the future.

Suggested Next Steps

We (NHSCFA) will assist and continue to support organisations with the development of local FRAs and LPE activity through a variety of means (webinars, forums, guidance).

We (NHSCFA) will look to engage with those key members of staff responsible at a local level for fraud risk activity (Risk managers).

Organisations should continue to manage FRAs in line with their organisations risk management policy whilst ensuring the content of FRAs falls in line with the standards set by the Government Counter Fraud Profession.

Organisations should continue to undertake and record fraud risk based local proactive exercises.

Organisations should ensure fraud prevention notices are recorded as local proactive exercises on Clue in a timely manner ensuring all outcomes are recorded as appropriate.

Objectives

To undertake an exercise applied to all Health Boards and Trusts in Wales who submitted a CFFSR in June 2022, to assess the level and detail of risk-based counter fraud proactive work undertaken, with specific focus on GovS013 component 3, GovS 013 component 6, GovS 013 component 8 and GovS component 10.

To support the sector with guidance and share good practice with stakeholders to promote the benefits of shared learning and ensuring the best possible return on investment for proactive counter fraud work undertaken across the sector.

- To understand the risk based counter fraud procedures in use across NHS Provider organisations for proactive work.
- To test compliance of NHS provider organisations with regards to the four GovS 013 components relevant to this exercise (3, 6, 8 and 10) for proactive work.
- To consider appropriate guidance and continued support that the NHSCFA could provide the sector.
- Highlight good practice within the sector and communicate the findings with our stakeholders
- To report on our findings to NHSCFA and to those NHS provider organisations who formed part of the exercise (Directors of Finance, Audit Committee Chairs, Fraud Champions and Local Counter Fraud Specialists). To publicise the findings of the thematic exercise across the sector.

Purpose

The purpose of the exercise was to provide assurance to Welsh Government that appropriate measures to prevent fraud, bribery and corruption within Health Boards and Trusts for those areas of fraud risk assessment, risk based proactive exercises, outcome-based metrics and appropriate usage of the NHSCFA approved case management system (Clue) were place. Where they were not in place, to make appropriate and meaningful recommendations to address any identified vulnerabilities.

Scope / Out of Scope

The exercise engaged with all Health Boards and Trusts in Wales. Those NHS organisations that commission services (Commissioners) and any organisation falling outside the mandatory requirements of the NHS Requirements (components) were out of scope.

Methodology

Organisation Selection

There are a total of 12 organisations in Wales however Digital Health Care Wales fall under Velindre NHS Trust for reporting. Therefore 11 were selected for the exercise and those selected were.

Aneurin Bevan University LHB
Betsi Cadwaladr University LHB
Cardiff and Vale University LHB
Cwm Taf Morgannwg University LHB
Health Education and Improvement Wales
Hywel Dda University LHB
Powys Teaching LHB
Public Health Wales NHS Trust
Swansea Bay University LHB
Velindre NHS Trust
Welsh Ambulance Service NHS Trust

NHS Wales Shared Services Partnership were included under the Velindre NHS Trust findings.

The organisations were asked to provide their risk management policy and evidence of local fraud risk assessments undertaken. All organisations engaged fully with that request and submitted the required material in a timely manner which was welcomed.

In addition, Shared Services Wales took part in the exercise given they had recently appointed their own LCFS lead and the organisation carried a high level of responsibility for higher risk fraud areas such as procurement, human resources and some finance functions such as payroll for the whole of Wales.

NHS Requirements Relevant to the Exercise

NHS Requirement 3 - The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body).

3 organisations (27%) had rated themselves as **Green** and meeting the requirement.

8 organisations (73%) had rated themselves as **Amber** and partially meeting the requirement.

Zero organisations (0%) had rated themselves as **Red** and not meeting the requirement.

NHS Requirement 6 - The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system.
Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.

8 organisations (73%) had rated themselves as **Green** and meeting the requirement.

3 organisations (27%) had rated themselves as **Amber** and partially meeting the requirement.

NHS Requirement 8 - The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during investigations and/or proactive prevention and detection exercise.

10 organisations (91%) had rated themselves as **Green** and meeting the requirement.

1 organisation (9%) had rated themselves as **Amber** and partially meeting the requirement.

NHS Requirement 10 - The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption.
Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

7 organisations (64%) had rated themselves as **Green** and meeting the requirement.

4 organisations (36%) had rated themselves as **Amber** and partially meeting the requirement.

Findings

Risk

We found that in most cases organisations with the continued support of their counter fraud service provider had begun to understand the concepts of local fraud risk assessments and in some instances, we were encouraged to hear that the LCFS had engaged with risk managers. It should however be noted that this was not the case for all organisations in Wales. An organisational summary is included within this report.

It was evident that there were varying degrees of compliance with NHS Requirement 3 with some organisations being at the beginning of their local fraud risk assessment work whilst others had grasped the understanding of the GCFP standard for fraud risk assessment and the importance of conducting local fraud risk assessments which would assist and inform their local proactive exercise activity and ensuring that fraud risk mitigation is undertaken and supported by hierarchy of the organisation.

Of the organisations we looked at for the thematic exercise all used Datix software to record risk assessments not all organisations had recorded their risk assessments in line with their local risk management policies and as such would be rated red for requirement 3. None of the organisations had rated themselves red on the annual CFFSR return submitted to NHSCFA. This was the area of most concern in general terms. Fraud risks should be treated and managed in the same way as any other risk formally recorded at a local level and local policies should be followed. It was also apparent that fraud was not referenced as a consideration in the local risk management policies.

We found that further support for our stakeholders will be required to reinforce the importance undertaking detailed FRAs in-line with standards and working closely with the organisations risk teams in order to better equip the organisation to fully understand their local risk areas and how then those risks can be addressed with actions.

We would encourage stakeholders to utilise the NHSCFA NGAGE platform to support their local fraud risk assessments to ensure that both the NHS Requirements and GovS013 functional standards are met.

Local Proactive Exercises (LPEs)

It was evident from the records held on Clue that the recording of LPEs and Outcomes resulting from fraud risk based LPEs was limited at the time of the assessment.

For the year 2021/22 across the 11 organisations a total of 35 LPEs had been recorded however 20 of those recorded were for 2 organisations, leaving some organisation without any recorded LPEs.

Organisations must remember that it is a requirement to record action against fraud prevention notices (FPNs) including no action required or a “not relevant” response. FPNs have been assessed centrally as posing a potential risk and therefore should be recorded locally to offer assurance to the organisation that FPNs are being actioned appropriately.

Organisations who do not record activity against FPNs could be in breach of NHS Requirements 6, 8 and 10 and the return on the CFFSR would suggest the majority of organisations would not have actually been compliant with these requirements.

We can say that more work must be undertaken to reinforce and publicise the importance of conducting fraud risk based LPEs so that limited resources are best spent more effectively with the aim of preventing and deterring fraud at a local level.

We can say that for those organisations who had recorded LPEs on Clue that the data entry was positive, and we were encouraged by the level of detail on some LPEs recorded (e.g. investigator notes). This can of course be improved with further support.

Recommendations

- NHSCFA to provide continued support and training to organisations via workshops or webinars in order to increase knowledge and understanding of both fraud risk assessments and LPEs.
- NHSCFA to reinforce the importance of fraud risk assessments and the targeted approach to LPEs so that LCFS resources are best spent more effectively.
- NHSCFA to explore the possibility of allowing access to Ngage for key staff within an organisation for eg deputy directors of finance, head of governance and head of risk.
- Organisation must record FRAs in-line with their own risk management policies to achieve an amber rating and once evidence supports review and evaluation in-line with those policies then a green rating would apply for requirement 3.

- Organisations to undertake comprehensive fraud risk assessments at a local level which should be reviewed and updated in line with the organisations own policies and procedures.
- Organisations must ensure that all FPNs are recorded on Clue as this will ensure the benchmarking dashboards accurately reflect the work being done to counter fraud at a local level. Failure to do so would result in a red rating for requirements 6, 8 and 10.
- Organisations to ensure outcomes from LPEs must be accurately recorded even if this is some time after the proactive exercise has concluded. For example, following recommendations it would be beneficial to revisit the exercise to review outcomes.

Individual organisational summaries

Organisation	Summary of findings	Recommendations
Aneurin Bevan University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. Which included recording risks on the organisations risk management software, Datix. LPE's and FPNs had been recorded and at the time of the assessment a total of 16 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded and all FPNs should be actioned and recorded.
Betsi Cadwaladr University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. Which included recording risks on the organisations risk management software, Datix. LPE's and FPNs had been recorded and at the time of the assessment a total of 5 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Cardiff and Vale University LHB	A number of FRAs had been written however at the time of the assessment no FRAs had been recorded on Datix which was a policy requirement. The LCFS lead did confirm that plans had been put in place to rectify this issue. The FRAs we had sight of were	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements.

	broadly written in line with GCFP methodology. LPE's and FPNs had been recorded and at the time of the assessment a total of 7 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• FRAs should be recorded in-line with local policy as at the time of the assessment a red rating would have applied for requirement 3. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Cwm Taf Morgannwg University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Health Education and Improvement Wales	We did not have sight of FRAs for the organisation. LPE's and FPNs had been recorded and at the time of the assessment a total of 5 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until

		this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Hywel Dda University LHB	We had sight of a number of FRAs that had been written broadly using the GCFP methodology. At the time of the assessment only 1 FRA had been recorded on the organisations Datix system. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Powys Teaching LHB	The risk management policy for Powys Teaching LHB stated that all risks rated 9 and below should be managed locally and intimated there was no requirement to record these risks on Datix. We had sight of a comprehensive spreadsheet of FRAs completed by the LCFS which broadly utilised the GCFP methodology.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. I would also be prudent to ensure fraud risk ownership is relevant and department specific and therefore to

	The concern would be the local ownership of the FRAs which should be owned where the risk is relevant. For example a risk relating to procurement should be owned by the procurement team and it was not clear if this was the case. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022	comply with their own policy fraud risks should be included on local departmental registers. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Public Health Wales NHS Trust	We did not have sight of FRAs for the organisation. LPE's and FPNs had been recorded and at the time of the assessment a total of 4 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Swansea Bay University LHB	We had sight of a comprehensive spreadsheet of FRAs completed by the LCFS which broadly utilised the GCFP methodology. However, when it came to recording risks on Datix and in-line with their own policy the LCFS had found it	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements.

	challenging at the time of the assessment to enable FRAs to be recorded on the Datix system. This meant that at that time the organisation would be rated red for requirement 3. It is important that the organisation treat fraud risks in the same way as all other risks. LPE's and FPNs had been recorded and at the time of the assessment a total of 1 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• FRAs should be recorded in-line with local policy as at the time of the assessment a red rating would have applied for requirement 3. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Velindre NHS Trust	We did not have sight of FRAs for the organisation. However we did engage with the LCFS for Shared Services Wales and expect FRAs to be written and recorded for this service arm of Velindre. LPE's and FPNs had been recorded and at the time of the assessment a total of 4 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Welsh Ambulance Service NHS Trust	LPE's and FPNs had been recorded and at the time of the assessment a total of 17 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local

		policy requirements, including the recording of FRAs on Datix. • Outcomes from LPEs should be accurately recorded and all FPNs should be actioned and recorded.

APPENDIX 2

INDEX OF LCFS INVESTIGATIONS AS AT 5th JULY 2023

Case	FIRST Ref	Health Body	Area	Subject	Status
1.	WARO/19/00145	ABUHB	NHS Staff	Falsify WLI claims.	CPS declined charging decision, No Further Action (NFA) criminal aspect. Civil recovery and GMC action impending.
2.	WARO/20/00020	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. Dismissed from employment on 21/10/2020 following disciplinary action. NMC sanction impending.
3.	WARO/21/00003	ABUHB	NHS Staff	Theft of medication.	Dismissed for gross misconduct on 10/08/2021 following disciplinary action. Police sanction Women's pathway. NMC sanction impending.
4.	INV/21/00276	ABUHB	NHS staff	Dishonest retention of salary overpayment.	At Merthyr Tydfil Crown Court on 6th September 2022, the defendant was sentenced to 8-months imprisonment, suspended for 12-months, was ordered to pay £1,124.69 investigation costs, pay £156.00 victim surcharge, and perform 100 hours of unpaid work. (The defendant had already repaid ABUHB in advance of the court hearing on 25th August 2022, against a fraud loss value of £21,389.69. NMC sanction impending.
5.	INV/22/00060	ABUHB	Member of public	NHS compensation claim.	Investigation ongoing.
6.	INV/22/00123	ABUHB	NHS staff	False declaration on job application form.	Investigation ongoing in joint venture with Gwent Police. Criminal prosecution impending.
7.	INV/22/00529	ABUHB	Member of public	Illegal supply of prescription drugs.	Joint investigation with Police. Defendant convicted at Newport Crown Court on 28/10/2022. 6 x firearms offences & 1 x possession-controlled drugs offence. Sentenced on the 16th May 2023 to 4 years imprisonment. Case now closed.

APPENDIX 2

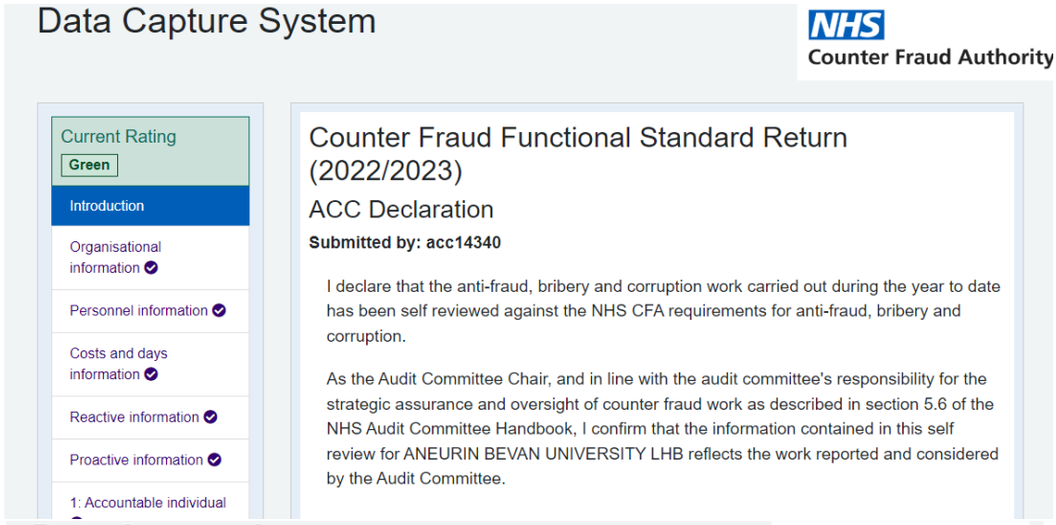
INDEX OF LCFS INVESTIGATIONS AS AT 5th JULY 2023

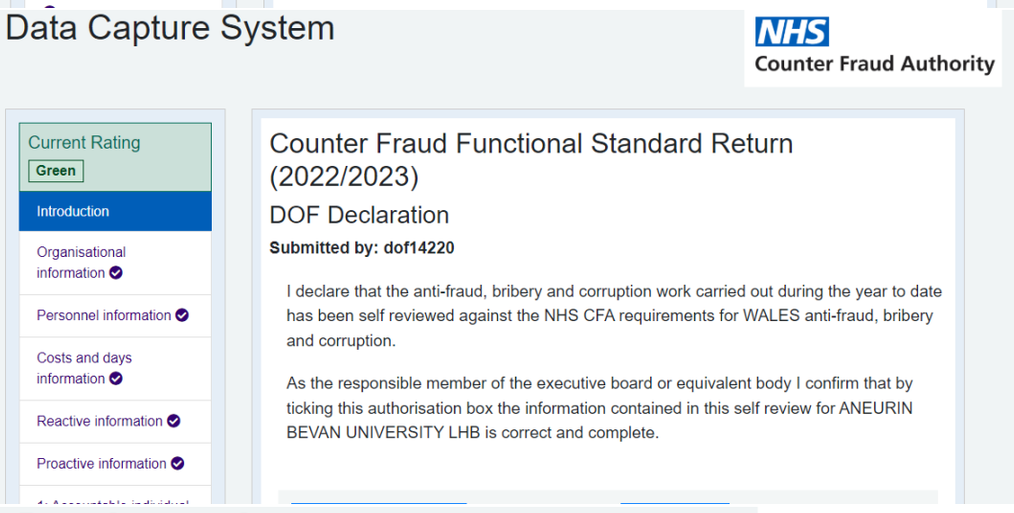
Case	FIRST Ref	Health Body	Area	Subject	Status
8.	INV/22/00690	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	NFA on criminal aspect. NMC imposed 18-month interim order on 27/05/2022. Restricted to work in Private Nursing Home in Tredegar. NMC action continuing.
9.	INV/22/00899	ABUHB	NHS staff	Working elsewhere whilst on sick leave.	Investigation concluded NFA on criminal aspect but awaiting disciplinary outcome.
10.	INV/22/01195	ABUHB	NHS staff	Theft of hospital prescription medication.	Police caution on 14/01/2023 as criminal sanction. Disciplinary action still impending due to staff non engagement.
11.	INV/22/01201	ABUHB	NHS staff	Timesheet fraud.	Investigation ongoing.
12.	INV/22/01391	ABUHB	NHS staff	Dishonest retention of salary overpayment.	Subject interviewed under caution. NFA on criminal & disciplinary aspect. Recovery of £24,000.00 implemented but only £200 paid back to date.
13.	INV/22/01414	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.
14.	INV/23/00258	ABUHB	NHS Staff	Timesheet fraud.	The subject has been interviewed under caution and a second interview will take place Q2. HR have been updated.
15.	INV/23/00674	ABUHB	NHS Staff	Timesheet fraud.	Investigation ongoing.
16.	INV/23/00761	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
17.	INV/23/00920	ABUHB	NHS Staff	Timesheet/Annual Leave fraud.	Investigation ongoing.
18.	INV/23/00921	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.
19.	INV/23/00922	ABUHB	NHS Staff	Working elsewhere whilst on sick leave.	Investigation ongoing.
20.	INV/23/00970	ABUHB	Member of public	False home address details to GP.	Investigation ongoing.

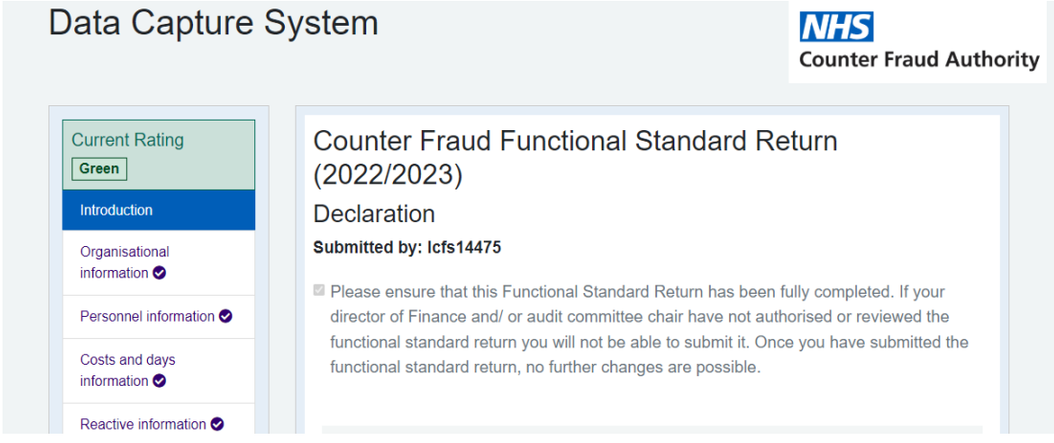
APPENDIX 2

INDEX OF LCFS INVESTIGATIONS AS AT 5th JULY 2023

Case	FIRST Ref	Health Body	Area	Subject	Status
21.	INV/23/01050	ABUHB	NHS Staff	Timesheet fraud.	The subject was interviewed under caution. NFA on criminal but passed to HR for disciplinary process.
22.	INV/23/01051	ABUHB	NHS Staff x4	Timesheet fraud/ Misuse of computers.	Two subjects have been interviewed under caution with a further interview of one of them to take place this Q2. Other subjects referred to HR.
23.	INV/23/01052	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.
24.	INV/23/01053	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.
25.	INV/23/01054	ABUHB	NHS Staff	Dishonest retention of salary overpayment.	Investigation ongoing.
26.	INV/23/01141	ABUHB	Member of public	False letter to GP, produced to supply medication.	Investigation ongoing.
27.	INV/23/01142	ABUHB	Member of public	Prescription /medication fraud.	Investigation ongoing.


Data Capture System
NHS
Counter Fraud Authority
Current Rating
Green
Introduction
Organisational information
Personnel information
Costs and days information
Reactive information
Proactive information
1: Accountable individual
Counter Fraud Functional Standard Return (2022/2023)
ACC Declaration
Submitted by: acc14340
I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for anti-fraud, bribery and corruption.
As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self review for ANEURIN BEVAN UNIVERSITY LHB reflects the work reported and considered by the Audit Committee.


Data Capture System
NHS
Counter Fraud Authority
Current Rating
Green
Introduction
Organisational information
Personnel information
Costs and days information
Reactive information
Proactive information
Counter Fraud Functional Standard Return (2022/2023)
DOF Declaration
Submitted by: dof14220
I declare that the anti-fraud, bribery and corruption work carried out during the year to date has been self reviewed against the NHS CFA requirements for WALES anti-fraud, bribery and corruption.
As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self review for ANEURIN BEVAN UNIVERSITY LHB is correct and complete.


Data Capture System
NHS
Counter Fraud Authority
Current Rating
Green
Introduction
Organisational information
Personnel information
Costs and days information
Reactive information
Counter Fraud Functional Standard Return (2022/2023)
Declaration
Submitted by: lcfs14475
Please ensure that this Functional Standard Return has been fully completed. If your director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 July 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lucy Windsor, Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The paper presents the Audit, Risk, and Assurance Committee (referred to as the Committee throughout the report) with an overview of all identified internal and external audit recommendations and current implementation status as at 31st March 2023.

The paper also seeks to provide an update on recommendations that have progressed since the last reporting period, where a revised deadline has been proposed, recommendations that remain outstanding, and an overview of management action plans that have now been completed in their entirety.

The Committee is asked to:

- **NOTE** the position in respect of overdue audit recommendations.
- **NOTE** the position in respect of complete audit recommendations.
- **APPROVE** the revised timescales for the **7** Internal and **3** External Audit Recommendations.

The Committee is also asked to:

- **AGREE** to the frequency of reporting moving from bi-monthly to quarterly on the basis that all long-standing recommendations have been closed.

The rationale for requesting a change in reporting frequency is the time required to ensure that the information reported to the Committee is adequately updated and can withstand rigorous scrutiny. The Tracker contains a large amount of complex information that requires meticulous attention to detail in order to ensure that the information that needs to be updated is accurate; the same is true for information returned.

To ensure that the Committee can be confident that the recommendations have been thoroughly reviewed and updated, and that the actions taken are stringent enough to manage or complete the recommendations, moving to quarterly reporting (once all longstanding recommendations have been closed) would provide enhanced assurance on the management of all audit recommendations.

Cefndir / Background

The Committee agreed to a revised approach to managing internal and external audit recommendations at its April 2022 meeting. The revised approach would improve internal and external audit recommendation management, as well as performance against agreed-upon actions.

At its subsequent meeting in May 2022, the Committee received a final report from Internal Audit regarding the 'Follow Up of High Priority Recommendations' and a review of the revised Audit Recommendation. The audit and review resulted in a positive outcome, with no new areas of concern identified.

In accordance with the Health Board's Internal Audit plan, a further 'Follow Up of High Priority Recommendations' is scheduled to be completed in Quarter 4 and will be reported to the Committee upon completion.

Following the implementation of the new approach, the Committee has been able to focus its attention on recommendations that have passed their original and revised completion dates, as well as those that were closed during the previous reporting period, to ensure that the Committee is carrying out its responsibilities in terms of thorough scrutiny in order to obtain assurance of the implementation and progress of Internal and External Recommendations.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking, 31st March 2023

Since the previous reporting period, 31st January 2023, work has been completed to update the master tracker to include all Internal and External Audit Recommendations up until 31st March 2023. Additional work is required to input recommendations from audit reviews completed in the first quarter of the financial year 2023/24 and to refine the information contained in the master tracker; this will be shared at the September Committee meeting.

The Committee has been provided with data regarding overdue and completed recommendations for quarter 4 of the financial reporting period 2022/23 for this iteration of the report.

Following the previous reporting period, which ended on 31st January 2023, several revised timeframes were agreed upon, leaving a residual position for any outstanding

internal and external recommendations. There were also a number of actions for which no implementation deadlines were provided.

The table below summarises the position between the reporting periods of January 31st and March 31st. The term 'Blank,' refers to recommendations that do not have an 'agreed deadline'.

Table 1

Number of All Overdue (OD) and Blank (B) Recommendations										
Lead Director	**Chief Executive Officer**	**Chief Operating Officer**	**Director of Digital**	**Director of Corporate Governance**	**Director of Finance & Procurement**	**Director of Nursing**	**Director of Public Health & Strategic Partnerships**	**Director of Strategy, Planning & Partnerships**	**Director of Workforce & OD**	**Total**
Q3 2022/23 January 31st	**1** OD	**46** (33 OD 13 B)	**20** OD	**1** OD	**5** B	**5** OD	**1** OD	**3** B	**2** (1 OD 1 B)	**84** 72IA 12EA
Q4 2022/23 March 31st	**1** *(1)	**17** *(6)	**19**	**1** *(1)	0	**2** *(2)	**0**	**0**	**0**	**40** 35IA 5EA
Total Number of Recommendations Complete in this Reporting Period										**44**

*(X) Revised number of Deadline(s) requested.

The position reported in this paper reflects the position as of 31st March 2023 in which **44 overdue/blank** internal and external recommendations have been **completed** and 10 have been assigned a revised deadline for implementation. In addition, there are **NO** internal or external audit recommendations without an agreed deadline.

In terms of overdue recommendations, the residual position is as follows:

- **35** internal (7 of the 35 have revised deadlines), and,
- **5** external recommendations (3 of the 5 have revised deadlines)

Since this reporting period 31st March 2023, recommendations with deadlines in the first quarter of the financial year 2023/24 would have become overdue. These will be updated in preparation for the next reporting cycle.

The data in the summary tables (2-5) provide a breakdown of completed and overdue internal and external recommendations by the Lead Director. The reframed reporting allows for greater transparency and accountability regarding the status of recommendations.

Internal Audit

Table 2 below summarises the position as at 31st March 2023 by Lead Director, in relation to the **35** (7 of the 35 have revised deadlines) **overdue** (past the original agreed-upon implementation date) internal audit recommendations:

Table 2

Lead Director	**Priority Rating of Recommendation**				**Total**
	High	**Medium**	**Low**	**N/A**	

Chief Operating Officer	**0**	**9**	**8**	**0**	**17**
Director of Corporate Governance	**0**	**1**	**0**	**0**	**1**
Director of Digital	**0**	4	**1**	**12**	**17**
TOTAL	**0**	**14**	**9**	**12**	**35**

The **7** internal audit recommendations with proposed revised timescales for implementation are listed below. Further detail relating to overdue internal audits can be found in Appendix 1.

- ***Pathology***
- ***High Voltage Electrical System Management (2020/21)***
- ***CYP Continuing Care (2 revised timeframes)***
- ***Waste Management (2 revised timeframes)***
- ***Policies***

On the basis that the Committee endorses the 7 revised timeframes, **28** internal audit recommendations will remain **overdue** as at 31st March 2023.

Table 3 below summarises the position reported as at 31st March 2023 by Lead Director, in respect of **completed** recommendations. **39** internal overdue/blanks have been **completed** in this reporting period.

Table 3

Lead Director	**Priority Rating of Recommendation**				**Total**
	High	**Medium**	**Low**	**N/A**	
Chief Operating Officer	**1**	**14**	**15**	**0**	**30**
Director of Digital	**0**	**0**	**0**	**1**	**1**
Director of Finance & Procurement	**0**	**0**	**0**	**2**	**2**
Director of Nursing	**0**	**2**	**0**	**0**	**2**
Director of Public Health & Strategic Partnerships	**1**	**0**	**0**	**0**	**1**
Director of Strategy, Planning & Partnerships	**0**	**3**	**0**	**0**	**3**
TOTAL	**2**	**19**	**15**	**3**	**39**

The information in Appendix 2 of this paper provides the Committee with an overview of completed recommendations resulting from internal audit review.

External Audit

Table 4 below summarises the position as of 31st March 2023, in relation to the **5** (3 of the 5 have revised deadlines) **overdue** (past the original agreed-upon implementation date) external audit recommendations:

Table 4

Lead Director	Priority Rating of Recommendation				Total
	High	Medium	Low	N/A	
Chief Executive	1	0	0	0	1
Director of Digital	2	0	0	0	2
Director of Nursing	0	0	0	2	2
TOTAL	3	1	0	2	5

The **3** external audit recommendations with proposed revised timescales for implementation are listed below. Further detail relating to overdue external audits can be found in Appendix 3.

- ***Quality Governance Review (2 revised timeframes)***
- ***Structured Assessment 2017***

On the basis that the Committee agrees to the **3** revised timeframes, 2 external audit recommendations will remain **overdue** as at 31st March 2023.

Table 5 below presents the position reported as at 31st March 2023 by Executive Director, in respect of overdue **completed** recommendations.

Table 5

Lead Director	Priority Rating of Recommendation				Total
	High	Medium	Low	N/A	
Director of Finance & Procurement	0	0	0	3	3
Director of Workforce & OD	0	0	0	1	1
Director of Nursing	0	0	0	1	1
TOTAL	0	0	0	5	5

The information in Appendix 4 of this paper provides the Committee with an overview of completed recommendations resulting from external audit review.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **NOTE** the position in respect of overdue audit recommendations.
- **NOTE** the position in respect of complete audit recommendations.
- **APPROVE** the revised timescales for the **7** Internal and **3** External Audit Recommendations.
- **AGREE** to the frequency of reporting moving from bi-monthly to quarterly on the basis that all long-standing recommendations have been closed.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Row No	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure evidence is available upon request	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the reccomendation?	Reporting Date
16	Internal	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating Officer	Service Improvement Manager	Medium	R2 The Flow Centre Team should:•review the current completion of the screening / transfer process documentation and establish a standard expectation of completeness;•provide refresher training to the team members, if required;•undertake periodic checks of all staff members, to ensure consistency and feedback any positive performances and improvements to individuals. This should also link into the PADR process;remind staff that the WAST incident number should be recorded to provide traceability; and•all screening questions shouldbe uploaded to CWS, where required.	Agreed. We will do this by:•implementing a staff review process, including an audit of referral information (this aspect is already implemented);•monitoringstaff performancee.g. logging in times and periodically listening to callsand to feedback onperformance;•addressing any training needs that ariseand link this to one-to-ones and the PADR process;•continuingto emphasise the importance of accurately recordinginformation e.g. WAST incident numbers, GP surgery etc.;•providingregular refresher training;and•hosting team meetings to share case studies / best practiceand address any issues / concerns that arise.	30/09/2021			Overdue	**18**			**Jun 23:** work has commenced on QPS and call audit				31/03/2023
17	Internal	Clinical Futures - Transport, March 2021	Reasonable	Chief Operating Officer	Service Improvement Manager	Low	R3 We recommend that the Flow Centre Team produce and monitor regular performance information over key risks within the process. For example, call waiting times.As this process is already underway, the Team should continue to identify other key performance indicators.This information should also link into individual performance within the Team, for training and improvement.	Agreed. We will:•clarify the audience and reporting requirements;•monitor performance information / KPIs on a regular basis;•identify the top five indicators;•develop a reporting dashboard;and•further refine performance reporting.	30/09/2021			Overdue	**18**			**Jun 23:** Remodelling of service and introduction of APP to FC so KPI to develop in line with new modelling				31/03/2023
63	Internal	Pathology	Reasonable	Chief Operating Officer	Assistant Directorate Manager	Low	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP	24/02/2021	**Sep-23**		Overdue	**25**	-5		All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilsed at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.	Workforce plans to be completed as soon as is possible Following completion, business cases may need to be produced and submitted for approval to recruit the additional staff required which will ensure Pathollogy service requirements will be met over the next five years and beyond.	31/03/2023
93	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021			Overdue	**21**			**May-23:** The Governance Structure will be discussed at the SIRO meeting. The meeting will be attended by the new Digital Director who will finalise these arrangements when he takes up post. **Mar-23:** The inaugural meeting for the Office of the SIRO is in May. It will be attended by a representative from Templar to explain to the membership of the group the purpose and aims of the group. The TOR was given approval from the SIRO. **Jan-23 -** Training for office of the SIRO completed and update to be provided to Exec Team Dec 22.				31/03/2023

94	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R2 A register of compliance requirements for all IM&T related legislation and standards across the whole organisation should be developed for the IGC along with a process for assessing status and reporting upwards to Committee.	Agreed. Currently the establishment, processes and mandate of informatics in ABUHB does not extend (with the exception of IG) beyond the directorate. In terms of accountability where devolved responsibility exists for information assets the same level of scrutiny and compliance should be applied. A corporate risk will be submitted with the recommendation of a strategic options appraisal for Board consideration and within this the role of Informatics as a Directorate will be considered along with other corporate and clinical divisions.	31/12/2021			Overdue	**15**		Mar 23 propose to close under Informatics Directorate as responsibility will sit with Rani	**May-23:** All policies are to be reviewed by the SIRO / DPO. **Mar-23:** The suite of 18 policies will be discussed at the inaugural meeting of the Office of the SIRO in May. Clarification of ownership is required so sign off can be completed. Templar are providing an elearning Cyber package for all staff in the organiosation to complete. **Jan-23 -** Revised and new policies completed and ready for sign off by the new SIRO which can then be disseminated through the GAGS and on the intranet. Identification of Senior Information Asset Owners and Information Asset Owners is the next stage and accountability to be assigned. **Aug 22:** New suite of 18 policies currently being internally reviewed and will be ready for policy group in mid September for sign off. **Jun-22:** Presentation to Board and establishing HBOTS over next 6 months with ToR and training delivery scheduled. New suite of policies to be completed in next 30 days and GAGS to help with rollout and implementation. Role for Comms to ensure dripfeed of information out within the health board. **Mar-22**: contract awarded to				31/03/2023
95	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R3 Management should consider enhancing the risk management process in place within the Health Board by providing an annual report that identifies risks that have a low likelihood, have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.	Accepted. Part of the new governance will focus on the objectives of the CDO as SIRO for the Health Board. Following the review and adoption of the Target Operating Framework and HB exec oversight a programme will commence to adopt new policies, training and performance management of ICT and Information Asset including training for Information Asset Owners.	31/03/2022			Overdue	**12**		Mar 23 propose to close under Informatics Directorate as responsibility will sit with DofCG	**May -23:** This will now be the responsibility of the Director of Corporate Services. **Mar-23:** Inaugral meeting of the Office of the SIRO scheduled to take place May 2023 **Jan-23:** Agreement for Rani Mallison to take on the role of SIRO, Training completed. New policies awaiting her review and identification of the SIAO and IAO roles in order to provide training. Update to Board being provided by Rani.				31/03/2023
96	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	ADI Governance and Assurance	N/A	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021		N/A	Overdue	**15**			**May-23:** Department risk management approaches are developing aligned to the corporate framework. A single risk register has been developed and is being rolled out, supported by internal risk management training/handholding. Once approaches are signed off, an informatics wide framework will be developed with new Digital Director. **Mar-23:** Clinical Assurance Process and Strategy is now approved and in place; Informatics Risk Management Approach under development **Jan-23 -** Domains aligning risk registers with the Corporate template and to publish so that there is visibility of the entire Informatics Risk to be held by the PMO. The first domain is completed (Programmes) SPD, Service Delivery, ICT Health Records and IG to follow. **Sept 22.** Awaiting the Octboer DDOB for formal sign off. **Aug 22:** ADI's have signed off the Clinical Assurance process however the DDOB meeting to approve was cancelled therefore moved to next meeting 18/10/2022 **June 22** Final Sign off requested from ADI's to present via CCIO report to DDOB on 12/7/2022. **May 22:**•Training has been provided				31/03/2023
97	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics	31/03/2021			Overdue	**24**			**May 23:** No additional TOF posts to be created pending new Director of Digital review Mar-23: Director of Digital will be reviewing the Target Operating Model once in post Jan-23: Paper has been submitted to CEO and is under consideration. **Sep-22.** The proposal for TOF				31/03/2023
98	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan	31/12/2022		N/A	Overdue	**3**			November 2021 Update: This is pending the TOF being funded and requires a full risk assessment to be conducted once the business analysis has been completed.				31/03/2023

99	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R7 A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.	Partially accepted. The Health Board commissioned a review of the Health Boards capacity and capability to deliver the strategy with recommendations for the Board to consider. This was scheduled for Q1 2020/21 but supporting the Health Board through the pandemic became the priority. Whilst this was not a self assessment against a maturity model as in NHS England or HIMMS it provides a comprehensive framework. The report also makes recommendations about the principle of "Once for ABUHB" which if accepted will lead to a baselining of assets, processes and convention outside of the current Informatics Directorate footprint. The recommendations from the planning of the new operating framework are planned to be delivered to Exec Team Q1 and Board Q2 2021.	30/09/2021			Overdue	**18**			**May-23:** HIMSS gap assessment site visit completed 4/5/23. Local report due 11/5/23. National report to be shared and discussed with Digital Directors in due course Mar-23: HIMSS Online survey complete and arrangements for on site visit underway Jan 23: Currently undertaking a HIMSS assessment as part of a national benchmarking exercise. **Sept 22**. Next steps have been agreed and a paper is drafted to be submitted in Oct 22. **Aug 22** An update on progress aginst the Digital Strategy was presented to the Health Board Chair and Exec Team in July 2022. A Digital Delivery Oversight Board (DDOB) has been established to review progress, support prioritisation and give executive oversight and direction to the informatics teams. **Jun-22:** financial planning has been completed, CDO to meet with Executive Director NP on next steps				31/03/2023
100	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021			Overdue	**21**			**May 23:** Benefits audit carried out and substantial assurance awarded. Funding to fully establish the PMO not yet secured however a portfolio view of all digital service requests and trnasofmration programmes has been developed along with a prioritisation and optimisation framework. DDOB has been stood down temporarily so prioritisation is done on an ad hoc basis with members of the exec team. Mar 23: Funding required for Head of PMO however, digital Portfolio manager recruitment underway in Programmes and benefits audit completed with substantial assurance. **Jan 23:** Awaiting funding for Head of PMO. Benefits management audit underway in programmes. **Sept 22.** This is part of the TOF paper submission Oct 22. **Aug 22:** Funding requested to progress Head of PMO to further support the portfolio development and implementation of the Digital Strategy. Report on the progress against the strategy shared with Board in July. Further update on benefits required for Nov/Dec audit committee. **June 22:** Portfolio dashboard under development and quarterly portfolio review & update meeting scheduled				31/03/2023
101	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	30/09/2021			Overdue	**18**			**May 23:** A divisional engagement model has been agreed for managing new service request and work in progress activities. A CSS meeting has been established. Urgent care to be established next and roll out to follow as resources allow. Mar 23: Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post Jan 23: Funded CNIO and Nursing Informatics lead. First Divisional meeting scheduled for December and await the outcome of the financial bid for the TOF **Sept 22.** Informatics have fully funded the Nursing Informatics Post and an increase in allocation for clinical leadership. The TOF paper being submitted in October 22 addresses the immidiate priorities for more effective engagement with Informatics in the HB. **Aug 22:** WNCR rollout plans include a nurse on each ward being champions for digital systems and GAG's promoting the need for diivisional champions to be identified by the SIAO's. **Jun-22:** agreement of co-funding Informatics and Nursing, subject to financial strategy for TOF implementation; a review of				31/03/2023

102	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R10 The Informatics Directorate budget should be set to reflect the actual need of the organisation. Where funding cannot be fully granted, the impact on the underfunded position of Informatics work and Digital Strategy delivery should be clearly stated and agreed with Executives.	Agreed. The Portfolio approach and executive oversight governance will provide the framework in which difficult prioritisation decisions must be taken to avoid historical best endevours approaches. Part of the recommendations from the review of informatics in ABUHB is to establish a dedicated Digital Investment Panel which will provide performance management and oversight to investments in digital. The Health Board recognises the need to prioritise and invest in order to deliver benefits and supports the principle of a benefits management realisation framework and strategy. Budget setting is taking place for next financial year with the aim to agree a growth commensurate with strategic objectives. The Target Operating model is designed to ensure capacity and capability of Informatics is fit for purpose and is currently being costed to inform a case for consideration.	01/10/2021			Overdue	**18**			**May 23 -** Budget seting now reviewed and budget increased to reflect previous years spend Mar 23: DDOB cancelled for Q4. Director of Digital has been appointed and a review of the Digital Delivery Oversight Board will take place once they are in post Jan 23: DDOB cancelled for Q3. IMTP Planning underway which will result in a financial appraisal going forward. **Sept 22.** Budget setting has been completed. DDOB now will consider resources for significant initiatives on a quartlerly basis. **Aug 22** Singificant work undertaken during the last quarter on budget setting and realignment of cost centres providing high level of confidence and clearly defined areas that still require investment. **Jun-22:** yet to be realised - to be discussed at Digital Delivery Oversight Board in Q3 **November 2021 Update:** A final internal challenge session is scheduled for December within the Division to ensure capacity and capability meets the Health Board requirements and will be presented in January 22 to the Digital Delivery Oversight Board before returning to Exec Team.				31/03/2023
105	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021			Overdue	**15**			**May 23:** work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Part of the HBOTS work programme to be established wiith SIAOs **Sept 22.** Paper is drafted and will be submitted October 22. **Aug 22** Pending financial strategy andTOF implementation **Jun-22**: subject to financial strategy for TOF implementation **November 2021 Update:** This is dependent on the TOF being implemented and the business analysis to be conducted to provide this input into an asset management system				31/03/2023
106	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	CDO	N/A	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021			Overdue	**15**			**May 23:** work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani **Jan 23:** Part of Cyber Resilience Programme- SIAOs in the process of being identified by new SIRO supported by Informatics- SIAOs will be trained and each will be accountable to identify assets within each division and directorate. **Sept 22.** SIRO training completed and new plan to be agreed in first Office of SIRO meeting. **Aug 22:** SIRO training scheduled in September and letters of delegatioN to be issued thereafter to the identified Senior Information Asset Owners **Jun-22**: Cyber Resilience programme commenced **May 2022:** contract awarded to consultancy Mar 2022 to implement recommendations - Office of the SIRO / delegated letters of authority to all information asset owners **November 2021 Update:** A report commissioned by the Health Board has been presented at the Digital Delivery Oversight Board and accepted. A proposal on next steps will be presented with associated costs to Executive Team in Q3 2021				31/03/2023
111	Internal	High Voltage Electrical System Management (2020/21)	Reasonable	Chief Operating Officer	Head of Estates (Maintenance & Operations)	Low	R4 a)Operational Procedure and Operations & Maintenance files should be reviewed, with out of date documents archived and current documents filed, as required by HTM 06-03.b)Site/substation log books should be maintained in the format required by HTM 06-01 (section 8).c)Records of inspections / replacement of equipment for which the UHB is responsible for should be maintained in the HV files(O).	Agreed, we recognise the benefits of improved record keeping, to make current documents more accessible.	30/06/2021	**Aug-23**	06/10/2022	Overdue	**21**	-4		70%	the new Divisional Director has asked (as Designated Person) for this work to be concluded alongside review of any related procedures and the Policy which is due for renewal.	Currently working from previous policy and existing litrature until documents have been reviewed		31/03/2023

146	Internal	Continuing Healthcare MH&LD	Limited	Chief Operating Officer	Divisional Director of Mental Health	Medium	R2.1 Clarity should be provided in terms of the roles and responsibilities of the Commissioning Team and the Care Coordinators, particularly associated with annual reviews.	2.1 The respective roles and responsibilities of the Commissioning Team members and Care Coordinators will be reinforced, ensuring clarity.	31/03/2022			Overdue	**12**			June 2023 - 'Role of Care Coordinators and Case Managers' document completed with input from Directorate Managers; Chris Jones attending Mental Health Ward Managers meeting 06.06.23 to discuss. Joe Edwards, Commissioning Practice Educator in post and will include this as part of training package from July 2023. Nov 2022 - 2.1 'Role of Care Coordinator and Case Managers' document produced for review. To be finalised by end of September 2022.				31/03/2023
165	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Low	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022			Overdue	**3**							31/03/2023
166	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022		N/A	Overdue	**3**							31/03/2023
167	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R3 Management should ensure that an Improvement Action Plan is developed promptly in order to avoid delays in implementation.	NIS Improvement Plan is already being developed by the Cyber Team. Thecompleted plan willbe presented for management review and sign off. Currently ABUHB are still awaiting the publication ofCAF Based Cyber Risk Register for the Health Board these risks identified by CRU following the CAF assessment may include remediations that will be incorporated into the Improvement Plan currently being developed.	31/07/2022			Overdue	**8**			**May 23:** work to commence shortly under SIRO Mar 23: Cyber continues to maintain the NIS Risk Register and Action plan against operational risks. Corporate level Cyber risks will transfer to HBOTS once this is fully erstablished **Jan 23:** Cyber continues to maintain the NIS Risk Register and Action plan. CRU are currently reviewing all risk registers submitted with a view to finding and reporting common risks to Welsh Government . This may result in a common approach for remediation being adpoted for all Boards.Cyber will await results and support any required actions to be taken as directed by CRU **Sept 22:** The completed and updated register is submitted. **Aug 22:** The ABUHB NIS remedial Action Plan has been used to support a CRU led workshop and support the remediation of risk identified on the CRU created ABUHB NIS Risk Register. Work is ongoing with internal stakeholders to complete a review of the ABUHB NIS Risk Register The completed register will be submitted to CRU during September 2022"				31/03/2023
168	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Digital		Medium	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022			Overdue	**6**			**May 23:** work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani **Jan 23:** Office of he SIRO has been established, implementation of supporting governance and structures are in progress allowing costs to be fully assessed and actions prioritised. **Aug 22:** The creation of the TOM and creation of the HBOTS is ongoing This will provide the risk management framework to allow costs associated to improvements to be managed and prioritised."				31/03/2023

169	Internal	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Chief Digital Officer	Medium	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security.5.2The risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022			Overdue	**6**			**May 23:** work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani **Jan 23:** Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established **Sept 22.** The reporting route is being established following the appointment of the new SIRO. **Aug 22:** Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				31/03/2023
182	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	1.1 Ensure that the Waste Management Policy has been reviewed/updated and reflective of the above findings. That the updated Policy is underpinned by formal Board Level approval with all key elements of WHTM 07-01 guidance incorporated.	1.1 The Waste Management Policy will be reviewed/updated and formally approved by the Board.	31/10/2022	**30/07/2023**		Overdue	**5**	-4		Policy is currently being reviewed/updated with new Director prior to engagement with wider stakeholders.				31/03/2023
184	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	1.3 Out-of-date policy / procedural documents published online should be updated.	1.3 All online policies and procedures will be reviewed and updated where necessary.	31/10/2022	**31/08/2023**		Overdue	**5**	-5		Waste Policy to be uploaded to Sharepoint once signed off. Date for publication will be subject to formal sign off internally				31/03/2023
197	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Service Manager	Medium	Incorporate the use ofthe recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process.Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	Medium1)RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2)Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthlyin line with QPS frameworkwith appropriately agreed action plans supported3)CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures.	31/12/2022	**30/09/2023**		Overdue	**3**	-6		Partial Completion 1) COMPLETED compliments being recorded on datix if receieved 2) All Wales KPI's not yet agreed to incorportae in our performance monitoring locally 3) CIVICA feedback implemented for Care Closer to Home and awaiting first report, wider implementation anticipated in the next 6 months	All Wales KPI still to be finalised			31/03/2023
200	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Divisional Nurse/ Division Lead for QPS	Low	Implement robust communicationmechanismsbetween the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc).Monitor the effectiveness of these forums and any new joint processes implemented.	Assistant Divisional Nurse / Division Lead QPS	30/11/2022	**30/09/2023**		Overdue	**4**	-6		Ongoing - Development of Complex Needs Pathway underway, Interagency collaborative meetings commenced, joint processes in draft form, Consultant Nurse JD in draft, expected to be advertised shortly	some concerns regarding differeing interpretations of the national framework and organisational responsibility between health and local authority	Vanguard training proposed by Welsh Government for Autumn 2023		31/03/2023
256	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Low	R1 The Project Execution Plan should be updated to reflect current governance arrangements	Agreed. The PEP will be updated.	31/01/2023			Overdue								31/03/2023
257	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R2 The role and responsibilities of the Primary Care & Community Estates Programme Board, in acting as the Project Board for major Primary Care projects, should be clearly defined in the Terms of Reference.	Agreed. The role of the Primary Care & Community Estates Programme Board, in acting as the Project Board will be defined and documented.	01/02/2023			Overdue				Change of Executive lead may result in rescheduling of PCC Estate Board Meetigns and ToR. To be established by COO & DD				31/03/2023
258	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R3 The Primary Care & Community Estates Programme Board should meet with the agreed frequency (6-weekly) as a minimum to ensure sufficiently regular oversight of the major projects within its remit.	Agreed	01/01/2023			Overdue				COO to establish frequency of PCCPB				31/03/2023
259	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R4 The constitution and capacity of the Primary Care & Community Estates Programme Board to effectively execute the Project Board role for all the Primary Care projects within its remit should be reviewed and confirmed.	Agreed. The governance structure will be reviewed	01/02/2023			Overdue				Change of Executive lead may result in redesign of Divisional Governance Structure. To be established by COO & DD. Awaiting new Project Board to be impletmented.				31/03/2023
260	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Low	R5 A standard and consistent range of project reports should be submitted to the Primary Care & Community Estates Programme Board, to support the 'project board' role and responsibilities of the forum (to be defined as per recommendation 2.1).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023	Transfer to Dof SP&P. Remit of the Capital Planning Team		Overdue				Transfer to Dof SP&P. Remit of the Capital Planning Team				31/03/2023

261	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Low	R6 Project Team meetings should be supported by a standard agenda, including submission of a Low standard and consistent range of project reports. This should include the Cost Report and external PM's progress report for information (albeit recognising the full detail of these technical reports may not be reviewed during the meetings).	Agreed. Improved reporting has been implemented at other projects and will be introduced at Newport going forward.	01/01/2023	Transfer to Dof SP&P. Remit of the Capital Planning Team		Overdue				Transfer to Dof SP&P. Remit of the Capital Planning Team				31/03/2023
263	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	medium	R8 A report should be tabled at the next Primary Care & Community Estates Programme Board meeting, presenting an update against each Gateway recommendation, and identifying any actions still outstanding.	Agreed	01/01/2023	Transfer to Dof SP&P. Remit of the Capital Planning Team		Overdue				Transfer to Dof SP&P. Remit of the Capital Planning Team				31/03/2023
270	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Low	R15 The Project Bank Account should be implemented as soon as possible.	Agreed. The UHB is awaiting a list of sub-contractors from the SCP who wish to join the PBA.	01/02/2023	Transfer to Dof SP&P. Remit of the Capital Planning Team		Overdue				Transfer to Dof SP&P. Remit of the Capital Planning Team				
272	Internal	Policies	Limited	Director of Corporate Governance		Medium	R1 The Health Board should review the types of policy documents retained and hosted, to determine if each of them should adhere to the Policy, for example, departmental standard operating procedures to be managed entirely within the respective division. Alongside this review, the document owner should be determined to ensure the responsibility remains with the most appropriate individual.	As part of a review of the Policy for the Management of Policies and Written Control Documents (WCDs), clarity will be provided on which WCDs are to be held centrally and which are to be managed within services and teams.A review of the central base (881 documents) is underway, working with divisions, to review the status of each document and respective owners.	31/03/2023	30/09/2023		Overdue	**0**	-6		**Jun 23** - The Policy on Policies is currently being reviewed and as part of the review the scope of WCDs to be held centrally. The proposed scope is that only organisational WCDs will be held and managed centrally; all local polices and procedures will be managed within respective Divisions. Departments. Thiis will be shared with key stakeholders in Q2 2023/24 for comment.				31/03/2023

Row No	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure evidence is available upon request	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the reccomendation?	Reporting Date
55	Internal	Pathology	Reasonable	Chief Operating Officer		Low	R1 The Pathology Team should consider updating the External inspection Policy to include one centralised repository for all external reportsthat incorporatetimescales for a responseand provides a clear overviewof progressacross all areas.	Will ensure reportsare maintained in a centralised repositoryand ensure the policyis updated accordingly	24/02/2022			Complete	13			Policy updated and inspection reports collated in one repository			Policy updated and inspection reports collated in one repository	31/03/2023
56	Internal	Pathology	Reasonable	Director of Operations	Pathology Governance Manager	Low	R2 a.All instances of non-conformance identified in the reports should be recorded centrally to support periodic trend analysisand in particular theCAPA module within QPulse.	a.Log UKAS inspection as one single CAPA within QPulse and update progress as per any other non-conformity	24/02/2022			Complete							Themes and trends included in policy for external reports and minutes of various meetings where discussed.	
57	Internal	Pathology	Reasonable	Chief Operating Officer	Pathology Governance Manager	Low	R2 b Periodic trend analysis / pattern identification should be completed across all instances of non-conformanceand used to identify common areas of concern for corrective/preventiveaction.	.Try to identify themes and trends across Pathology, though inspections are held at different times of the year for each discipline so not as straightforward.	TBC			Complete	#VALUE!						Themes and trends included in policy for external reports and minutes of various meetings where discussed.	31/03/2023
103	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital		N/A	R11 The Informatics Directorate should develop an overarching workforce plan that sets out the resource gaps together with the skills gaps and how they are to be resolved. The plan should consider apprenticeships, coordinated departmental development and partnerships in order to maximise the use of limited financial resource.	Planning despite COVID continued on the Operating Framework based on existing mandate and footprint of Informatics portfolio. This addresses key areas of competencies and capacity. This has been supported activity with HR & OD and Finance. The new structure proposal reflects the Digital Strategy and Operating Framework but will require scrutiny challenge and approval.	30/09/2021			Complete	18		Jan 23 Propose Closure.	"Jan 23: Working through SOP for training and prioritisation of requests to be agreed. Skills profiles being matched with JD's and engage on national task and fiish group to provide benchmarking Sept 22. The DIrectorate now has a small but dedicated budget for training and development to support the PADR and workforce planning agenda. Aug 22 Register of training opportunities, expressions of interest forms to be completed and assessed by senior manager with identification of funding available if applicable. Jun-22: Limited training budget identified and PMO have list of training opportunities available to staff. Agreement on Process and prioritisation of training to be undertaken in the next quarter Mar-22: prioritised and phased cost model submitted November 2021 Update: The Informatics service is engaging iwith Health Education and Improvement Wales to further develop Health Informatics apprenticeship pathways from entry level. The service is			Systems established - propose to close the reccomendation.	31/03/2023
121	Internal	Well-being of Future Generations (Wales) Act 2015 (2018/19)	Reasonable	Director of Public Health		High	R1 The Wellbeing of Future Generations Act Programme Boardshould include a review of the objectives and the progress against them as part of itsagenda, to ensure objectives are fit for purpose and the activities required to meet them are identified and monitored. 2) EachProgramme Board should be chaired by the Executive Lead in order to provide leadership, monitor effectivenessand highlight the importance of attendance. 3) Poor attendance at the Programme Board should be taken forward by the Executive Lead in order to ensure that it is rectified.	Agreed1.Thereview of the Wellbeing Objectiveswill be undertaken in conjunction with a broader review of where these objectives sit in the context of other Organisational priorities and ambitions. A landscape review/mapping of these various aspects will need to be undertaken in conjunction with the ABUHB Planning Teamtoinform the review of Well-being Objectivesas part of the IMTP process.The Programme board will include a review of progress against objectives as part of its agenda. 2.Programme Board meetings will be moved from a monthly to a quarterly basis and will be chaired by the Executive Director of Public Health and Strategic Partnerships. This will be supported bysub-Board meetings.3.The Executive Director of Public Health and Strategic Partnerships will provide WbFGA	31/12/2019	**Mar-23**	06/10/2022	Complete	39	0		April 2022 Update: the review of the Wellbeing objectives continues to be put on hold due to the prioritisation of the response to the Covid-19 pandemic. ABUHB is actively engaged in the process to agree a new collective set of Gwent PSB Wellbeing Objectives which will subsequently inform the review of the ABUHB Wellbeing Objectives' August 2022 Update: No change from April position. The pandemic response continues to divert leadership capacity away from this work, and the PSB Well-being Plan remains in draft ahead of consultation in the autumn. Nov 2022 - HB needs the PSB to agree collective WB objectives as part of teh Gwent plan and review our individual well being objectives as well as any indivdual ones. Actively contributing to development of the	Integration of the WBFGA within ABUHB has been led by the Public Health Team. Re-deployment of significant staffing capacity into the COVID-19 pandemic response has created a barrier to leading this work and responding to the audit recommendations since 2020. There is also an interdependency with the Gwent PSB and work taking place to develop a new well-being plan for 2023	The risk is being mitigated by aligning completion of the recommendations with the Gwent PSB planning cycle. To close down this risk the product of work to develop a Gwent well-being plan needs to be published which will not happen before the end of 2022/23.	The Wellbeing Plan went to the Board in March 2023 and was approved	31/03/2023
136	Internal	GUH: Quality Assurance	Reasonable	Director of Strategy, Planning & Partnerships		Medium	R1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	Agreed	TBC			Complete	#VALUE!			**June 23:** Gateway review process complete and post opening evaluation provided to Board			Gateway review process complete and post opening evaluation provided to Board	31/03/2023
137	Internal	GUH: Quality Assurance	Reasonable	Director of Strategy, Planning & Partnerships		Medium	R1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional models.	Agreed	TBC			Complete	#VALUE!			J**une 23**: GUH Functions finalised and facility open. Ongoing review via ELGH programme			GUH Functions finalised and facility open. Ongoing review via ELGH programme	31/03/2023
138	Internal	GUH: Quality Assurance	Reasonable	Director of Strategy, Planning & Partnerships		Medium	R2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility .	Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	TBC			Complete	#VALUE!			**June 23:** Reported via Estates Group and Decarbonisation Programme			Reported via Estates Group and Decarbonisation Programme	31/03/2023

183	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	1.2 Waste management operational control procedures review dates should be updated following each review.	1.2 OCPs will be formally reviewed with associated record of actions.	31/10/2022			Complete	5						OCPs are held online in Environmental Management System folder with version controlled hard copies available at each hospital site. OCPs are checked every 6 months during external ISO14001 audit	31/03/2023
185	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Low	2.1 Enhancement of the Waste Management Policy to include staffing groups as identified by the WHTM 07-01 guidance.	2.1 Staffing groups not recorded on OCP training evidence but recorded on induction training for Facilities and Clinical staff. To be recorded on all training sessions going forward.	TBC	N/A	N/A	Complete	#VALUE!						Staffing groups added to Waste Policy (currently being reviewed/updated). This action is completed as in revised policy.	31/10/2022
186	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	2.2a The training needs assessment should be reviewed and enhanced, encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID).	2.2a Training needs assessments will be reviewed and updated where necessary.	31/10/2022	28/06/2023		Complete	5	-3					Environmental Training Needs Analysis reviewed and updated (30/04/23)	31/03/2023
187	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	2.2b Management should investigate options to provide waste management/recycling/green agenda training to all UHB staff.	2.2b Provision of online training has been discussed and could be implemented within ABUHB, however we believe it would benefit from an all-Wales approach. This could potentially be coordinated via Welsh Health Environmental Forum	TBC			Complete	#VALUE!	0		consideration has tken place and will need to be concluded nationally.To be tabled as an agenda item at the next Welsh Health Environmental Forum	Coordination of approach across all HBs.			
188	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	3. A consistent approach should be taken to the waste stream used for disposal of offensive (but non-infectious) PPE, in public areas within the hospital sites - based on official guidance and management decision.	3. This is a recurrent issue across the country and every effort is made to ensure correct segregation through waste audits, spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management and Divisional Director. These measures will continue to be employed along with enhanced communication.	TBC			Complete	#VALUE!	0						
189	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	4. Staff will be reminded of the importance of complying with waste management operational procedures including (but not exhaustive): • the maintenance of secure waste storage areas; • the correct classification and disposal of waste; • the correct labelling of all waste items (including sharps)	4. As with Management Action 3 these are common, ongoing issues at all sites. Internal audits, ISO14001 audits (external), spot checks and walkarounds by Environmental Team, Compliance Team, Senior Management, Divisional Director and external auditors along with enhanced communications will reduce instances going forward	TBC			Complete	#VALUE!	0						
192	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	6.1a Recommendations / non-conformities arising from internal (pre acceptance audits) and external audits should be monitored via the central tracker.	6.1a All non-conformities (NCs) and recommendations are recorded by a central tracker spreadsheet. At the time of the audit, the tracker had not been updated with the latest NCs. All NCs/recommendations will be recorded as soon as raised/published. This would be reviewed every 6 months as part of external ISO14001 audit.	TBC			Complete	#VALUE!	0					All non-conformities are recorded online - NCN Register > EMS folder. This document is checked every 6 months during external ISO14001 audit	
193	Internal	Waste Management	Reasonable	Chief Operating Officer	Environmental Manager	Medium	6.1b Audit non-conformities, and progress towards actioning the same, should be reported to an appropriate forum.	6.1b Audit outcomes will be raised on an exception reporting basis to the Health & Safety Committee which has direct escalation to Corporate H&S and Exec Board.	TBC			Complete	#VALUE!	0					The Strategic Compliance Group replaces the Divisional H& Committee - first meeting to be held 15/06/23. Minutes to be recorded at each meeting	
198	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Divisional Nurse / Division Lead for QPS	Medium	Develop quality assurance mechanisms to assess the quality of:•CYP CC assessments;•care delivered by the CCNS team; and•care delivered by external providers (respite and commissioned CYP CC).Incorporate the QA mechanisms into the CYP CC Policy.	1)Quality Assurance mechanisms have been under review and considered through the multiagency CC development group. This to be finalised and rolled out across services2)CC policy will reflect clearly the mechanisms used for assurance	30/11/2022			Complete	4						Robust QA process in place that is evidence based. CC policy updated	31/03/2023
199	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Assistant Divisional Nurse / Division Lead QPS	Low	Acceptance of target risk scores outside the tolerance levels should be made at an appropriate level and clearly documented in the risk register.	1) Risk Register to be reviewed in light of service development and transformation opportunities. 2) Tolerance levels of risk for the service will be mitigated as far as possible within this workstream, clearly identified and understood with required transformation changes supported by both Division and Executive team.3) Ongoing monitoring and scrutiny at Division/Executive on 2 monthly basis	30/09/2022			Complete	6						Risk Register updated accordingly. Transformation of schools being planned in line with all Wales strategy Can be accessed via DATIX	31/03/2023

201	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Senior Nurse & Practice Educator	Low	Develop a CCNS Training Strategy to bring together and provide oversight for existing training activities.Implement a sustainable rolling programmeof practical CYP CC training.Monitor the impact of the resource issues on training and competencies to ensure they are not adversely affected.	1)Ongoing comprehensive training programme has re-commenced and is monitored for compliance. Compliance of training programme is currently affected by safe staffing needs –Division will continue to monitor expected improved compliance withmitigated workforce challenges2)Compliance to be reviewed two monthly as per QPS framework and to allow for implementation of follow up actions. Reported to DivisionalManagement Team	30/11/2022			Complete	4							COMPLETED 1)comprensive training programme in place for new starters and annual training for existing staff monitored by Senior Nurse and Practice Educator 2) Compliance reviewd on a monthly basis with Senior Nurse and Practice Educator	31/03/2023
202	Internal	CYP Continuing Care	Reasonable	Chief Operating Officer	Division Director / Chair for CCC Panel	Low	Include links to the following within the CYP CC Policy to provide full clarity on requirements:•relevant laws and regulations;•relevant Health Board policies and procedures, e.g., those relating to escalation and concerns; and•relevant local processes not already reference, e.g., local procedures to support implementation of Health Board escalation and concerns.Include all roles and responsibilities and reporting lines for completeness, even though they follow the Divisional structure.Inform CCNS staff of recent updates to the CYP CC Policy and where the Policy is stored.	1)Suite of policies and procedures have been undergoing review to ensure they are updated and make reference to concurrent local and UHB Policyas well as the wider National Policy and Legislation2)Policies and procedures, guidelines, standardsto be registeredon the Intranet A-Z Policies and Procedures, and the Children's community nursingstaff pages of Healthier Together Website for ease of access for the wider team3)Terms of Reference updated and awaiting final Division approval/sign off.4)Updated Continuing Care Policy	30/11/2022			Complete	4							Continuing Care Policy Updated and published 2022 COMPLETED 1) Continuing to review policies ensuring local and national policy and legistation is incorportaed 2) policies uploaded healthier together and intranet 3) Terms of refernce updated and approved Sep 2022 4) cc policy in date	31/03/2023
225	Internal	Decarbonisation - Advisory	Advisory	Director of Finance & Procuement	DPB & Workstream Leads	N/A	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	Agree. Appropriate governance structures for the DPB and subsequent workstreams have been established with ToRs for both DPB and workstreams complete	31/12/2023			Complete	-9								31/03/2023
228	Internal	Decarbonisation - Advisory	Advisory	Director of Finance & Procuement	DPB & Head of Communications & Comms/Training/Digital Workstream Lead	N/A	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	Agree. SusQl training has been rolled out to relevant officers. ABUHB would support the development of an All-Wales training package	TBC			Complete	#VALUE!								31/03/2023
241	Internal	NCN Final Report	Reasonable	Director of Primary, Community Care and Mental Health		Low	R1 The Health Board uses the term NCN to describe each of their cluster groups. The word NCN should be used instead of clusters in documents to prevent any misunderstandings.	The Executive Team have agreed to the use the term NCN rather than cluster groups and NCN Development Programme rather than Accelerated Cluster Development Programme.	Complete			Complete									
243	Internal	NCN Final Report	Reasonable	Chief Operating Officer		Medium	R3 Workforce planning should be more detailed within the NCN plans. If the NCNs want to implement certain projects or initiatives, there should be a clear understanding of how that will affect the workforce in that area. Given GP workforce requirements are so challenging, producing a workforce report that details where GPs are based, and who may be available to cover certain locations when required etc may be useful.	The newly appointed Workforce & Organisational Development Transformation Project Manager in the NCN Office will support the NCN Leads and Borough locality team to develop workforce plans to implement specific projects, initiatives or models of care. The National Workforce Reporting System (NWRS), hosted by Shared Service Partnership, has been analysed to identify areas where there are shortages in the GMS workforce. This information formed the basis of a recent round of NCN sustainability meetings and a Board Briefing session. The Executive Director for Primary Care, Community Services and Mental Health has re-established the Primary Care Sustainability Board which will respond to the workforce issues through a costed action plan.	01/04/2023			Complete	0			The national ACD/NCN Programme has 7 outcomes defined that link to the processes and infrastructure required to achieve the Primary Care Model for Wales outcomes. The 2 year programme provided national ministerial milestones alongside a readiness checklist for the initial transition year. The national team are currently developing a similar evaluation approach to the second year of funding which will see the initiation of KPI Dashboard, which is anticipated to be shared in a draft version towards the end of December, with an anticipation of a finalised version being available for 2024/25. Locally, the NCN teams are developing a measurement framework to demonstrate outputs of the programme at a delivery level.				31/03/2023
245	Internal	NCN Final Report	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Low	R5 Management should review the structure of the ACD/NCN programme and understand whether a more streamlined approach could be undertaken, to best utilise the resources available.	The Primary Care and Community Service Division has sponsored a report to the RPB and ABUHB Public Board about a suitable governance structure for NCN planning and delivery which meets the Ministerial milestones.	01/12/2022			Complete								The RPB agreed the governance structure for the programme on 31/10/22 and this was ratified at the ABUHB Public Board meeting on 30/11/22.	31/03/2023
246	Internal	Unified Breast Unit at YYF	Reasonable	Chief Operating Officer	Associate Director of Capital	Medium	R1 Treatment of charitable funding and application should be explicit in project cost reporting.	Agreed. The FBC cost form did show this as a separate funding item on FBC 7 (note: it was in the sum of £150k incl. VAT) but the Welsh Government approval stated the funding total of the entire sum. Welsh Government have been notified and are awaiting their clarification.	31/01/2023			Complete									31/03/2023

247	Internal	Unified Breast Unit at YYF	Reasonable	Chief Operating Officer	Associate Director of Capital	Low	R2 The PEP should be updated to reflect the current stage of the project	Agreed. The PEP will be updated to show current position	31/01/2023			Complete								31/03/2023
251	Internal	Unified Breast Unit at YYF	Reasonable	Chief Operating Officer	Associate Director of Capital	Low	R6 The PEP should define the integration of the contractual change control procedures and the UHB's Scheme of Delegation.	Agreed – the PEP will be updated to reflect this.	31/01/2023			Complete								31/03/2023
254	Internal	Unified Breast Unit at YYF	Reasonable	Chief Operating Officer	Associate Director of Capital	Medium	R9 Risk registers should include risk costs, risk owners (named individuals), and time parameters for risk mitigations.	Agreed. A risk register meeting will be held to address the recommended inclusions.	31/01/2023			Complete	2							31/03/2023
255	Internal	Unified Breast Unit at YYF	Reasonable	Chief Operating Officer	Associate Director of Capital	Low	R9 To enhance reporting, an exception report should be published of targeted risk mitigations not achieved.	Agreed. This will be shown on the Project Highlight Report for discussion at Project Board, should anything need to be highlighted, rather than a separate report.	31/01/2023			Complete								31/03/2023
262	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Divisional Director of Primary & Community Care	Medium	R7 The UHB Service risk register should be developed as soon as possible, with key risks reported to the Project Team and Programme Board on a routine basis (see also MA2).	Agreed. The need for the development of the risk register was raised at the last Project Team meeting.	01/02/2023			Complete							Risk register in place	31/03/2023
264	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer		medium	R9 At Future Projects Target cost / tender reports should be presented to the Project Board for scrutiny and approval.	Actioned since fieldwork.				Complete								31/03/2023
266	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer		Low	R11 At future projects Contracts should be executed before works / duties commence.	Agreed. We will endeavour to have contracts in place prior to duties commencing going forward at future projects.	TBC			Complete								
267	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer		Low	R12 At future projects Contracts should be dated.	Agreed. Signing process to be reviewed and strengthened.	TBC			Complete								
268	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer		Medium	R13 At future projects Contracts over £100k in value should be signed by both the Chief Executive & Chair in line with the Standing Orders (Scheme of Delegation).	Agreed. Approval and signing process to be reviewed, along with communication to teams in respect of delegated limits and associated requirements for authorisation	TBC			Complete								
269	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Project Director, with support from Capital Finance and the external Cost Adviser	High	R14 The UHB should ensure cost information is adequately scrutinised and understood in a timely manner to feed into routine WG updates (via the PPR process), and to allow for timely exception reporting if required.	Agreed.	TBC			Complete								
271	Internal	Newport HWB Centre	Reasonable	Chief Operating Officer	Project Director	Low	R16 KPIs should be submitted as required by the D4L Framework.	Agreed. Note that during this period the project was awaiting FBC approval and had not commencement on site. There would have been limited performance matters to measure.	01/01/2023			Complete								31/03/2023
294	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing		Medium	R2 We recommend that divisional management teams include within their approval emails for off-contract agency confirmation that all pre-requisite checks have been completed. This could take the form of a small template checklist. In addition, there should be a limit to the number of shifts that can be approved for each email request / approver.	Staff requesting off-contract agency reminded of the need to ensure it is confirmed via email that all stages of the escalation process have been considered prior to escalation to off-contract agency.	01/02/2023			Complete				**Jun 23:** Updated protocol published			**June 23:** Nurse Staffing Levels Wales (2016) Act Operational Framework and Escalation Process - approval date and review date added to the framework The Protocol for requesting, authorising & booking bank and agency clinical workers Standard Operating Procedure" has been updated by WOD	31/03/2023

295	Internal	Use of Off-Contract Agency (Nursing)	Limited	Director of Nursing	Assistant Director of Workforce	Medium	R3 We recommend that the Health Board issue best practice guidance prescribing the unfilled shift escalation timeline. This should encompass the end-to-end process requirements, to assist divisional staff in managing the process of filling roster gaps. There may be exceptions to 14 day rule, but these should be defined, with an appropriate approval process in place	The Off contract Agency Request Escalation process outlines the various steps for filling shifts with agency. There are not timelines recommended and this was fit for purpose during the covid period. However, whilst mentioned in the matters arising the recommendation does not acknowledge that these recommendations have been amended in October 22 as part of the VPR programme of work. The Resource Bank Rules came into effect in October 2022. The application of the 14 day rule for sending shifts to contract agencies has now been extended to 28 days, this is from the point the roster is released. This is to ensure the majority of shifts go out to substantive and bank workers in the first instance. However, it is acknowledged that rosters are live and will continually change as staff become absent due to a variety of reasons such as sickness, compassionate leave or demand increases. During these circumstance decisions will need to be made in regards the most appropriate means to fill shifts at short notice to ensure patient safety.	Completed October 2022 – reviewed and redistributed January 2023.			Complete									31/03/2023

Row No	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure evidence is available upon request	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the reccomendation?	Reporting Date	
8	External	Structured Assessment 2017	Not Rated	Chief Executive	Assistant Director of Comms and Engagement	High	R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	The Health Board will undertake a review and refresh its Citizen Engagement Strategy in line with the Clinical Futures Programme and IMTP. The Health Board will also continue to take forward its programme of staff engagement in line with the Clinical Futures Programme.	31/07/2018	**Sep-23**		Overdue	**56**			May 23 - The Communication and Engagement Strategy will be presented to Board in September for approval		Low risks determined as work is ongoing with the public, however staff enagement sits within Workforce and OD.		31/03/2023	
9	External	Structured Assessment 2017	Not Rated	Director of Digital	CDO	High	R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Boards plans	A Strategic Outline Plan was developed for the Welsh Government in October 2016, which asked for a cost analysis to implement the Welsh Government E-Health and Care Strategy to assess the potential resource implications for Wales. The Health Board is currently revisiting the Strategic Outline Plan and Strategy in the light of the financial context and has also developed a new IMTP for Digital with ten priority areas linked to this Plan. The Health Board has undertaken a review and benchmarking exercise in order to	31/03/2019			Overdue	**48**			**May-23:** proposal presented to Nicola, Awaiting final approval to action budget setting in mth3. **Mar-23:** Budget setting for 2023/2024 is underway **Jan-23:** No further update this quarter **Sept-22:** ABUHB is contributing to a national benchmarking exercise including finance, human resources, and digital maturity. Locally formal budget setting has taken place. The Digital Delivery Oversight Board will take account of reources in quarterly meetings where significant				31/03/2023	Identified as outstanding in Structured Assessmen t 2022 - There has continued to be increased investment in informatics both in
12	External	Structured Assessment 2018	Not Rated	Director of Digital	Head of Information Governance	High	R3 The Health Board should improve its information governance arrangements by: • improving compliance with the information governance training programme to reach the national rate of 95%;	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bi monthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	01/03/2020			Overdue	**37**	1476		**May-23:** The current training compliance is 79%. The new training package from DHCW has still not been launched. Annual reports are being written for each of the Divisions highlighting areas where improvements to their training compliance is required**.** **Mar-23:** The current training compliance is 78% for the organisation. there will be a major communication exercise undertaken by IG commencing in April with the focus on getting an improvement in the compliance rate. Hopefully by then the new national training package will be made available by DHCW. **Jan-23 -** First Governance and Assurance Board held and will be reporting into the Office of the SIRO. The Health Records module has been provided to the All Wales e-learning for incorporation into the new elearning launch. Final review is expected at the end of November. Monitoring will be improved as this will go into ESR and is now part of a national programme of work **Aug-22:** The Information Governance Unit have been engaged with national IG leads to create a new IG training programme	Identified as outstanding in Structured Assessment 2022 - The pandemic has hindered progress	Non compliance reports are being sent to senior managers within Divisions to ensure that compliance is monitored and actioned in these areas. Where non-complance persists targeted escalation routes have been established and the appropriate corrective action will be taken. Promotion of the audio learning tool for staff groups that have dificulty in leaving the workplace or access to computer systems and e-learning will be facilitated by the IG team and attendance recorded.		31/03/2023	
215	External	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R6 The Health Boards quality assurance framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is reasonably comprehensive at a corporate level, it doesn't fully articulate the operational structure and processes for quality and safety. The Health Board should:•complete its review of thequality and safety framework toensure that flows of assuranceare appropriate, and that the •framework functions asintended.•articulate the operationalstructures and processes forquality and safety within thequality assurance frameworkand how they align with thecorporate structure to provide a'floor to board' assurance.	The Quality Assurance Framework will be reviewed to assess fitness for purpose and alignment to the BAF. The revised Quality Assurance Framework will include the operational structures and processes.	31/10/2022	**31/07/2023**		Overdue	**5**	-4		**June 23**: Due to be presented to Executive Committee and PQSOC in July 2023				31/03/2023	

219	External	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R8 The General Surgery directorate has recently established its own patient safety and quality group. However, the group does not have a terms of reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations. We note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:•review the operational patientsafety and quality groups toensure they are effectivelysupporting the Health Boardsquality governancearrangements.•ensure that other operationalmeetings / forums providesufficient focus on quality andsafety alongside finance,performance, and operationalmatters.	The patient, quality and safety structures for each Division will be reviewed and outlined in the revised Quality Assurance Framework (see R6).Divisions will be reminded to ensure a robust focus on patient quality and Safety through Divisional and Directorate meetings.	31/10/2022	**31/07/2023**		Overdue	**5**	-4		**June 23:** Quality Assurance Framework due to be presented to Executive Committee and PQSOC in July 2023				31/03/2023

Row No	Audit Type	Report Title	Assurance Rating	Director	Responsible Officer	Ref / Priority	Recommendation	Management Response	Agreed Deadline	Revised Deadline	Revised Deadline Approved by Audit Committee	Due	No. of months past original agreed deadline	No. of months past Agreed Revised deadline	If closed and not complete, please provide justification and ensure evidence is available upon request	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the reccomendation?	Reporting Date
87	External	Taking Care of the Carers (Oct 2021)	Not Rated	Director of Workforce & OD		N/A	R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	The Health Board has initiated an innovative 12-month engagement programme called "#PeopleFirst, #CynnalCynefin, reconnecting our workforce". The origins are within the values of the Health Board and is a collaborative programme delivered by Wellbeing, OD and the Executive Board. The programme aims to re-connect staff to each other, to managers and senior leaders to empower them to raise and solve local problems locally, raise concerns to a higher level and offer the experience of feeling heard. As of December 2021, the project team have run 6 hospital site-based events, interacted with over 50 staff who have raised over 90 issues which we are working on. The project continues into the new year with cross-executive support.	31/12/2022			Complete	**3**	1476		June 2023: 1) As a quality assurance measure, an EQIA Group has been established to monitor EQIAs. 2) Screening tool has been developed and is being implemented	Resources and capacity		New EQIA template and evidence from working group	31/03/2023
216	External	Quality Governance Review	Not Rated	Director of Nursing	with Clinical Executives	N/A	R7 The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.	A review of roles for QPS across Divisions will be undertaken with the aim of implementing a consistent approach (this will include time for leads to undertake their role effectively).	31/10/2022			Complete	**5**	1476		**June 23**: All Consultant Surgeons with a lead role for quality and patient safety are enabled to retain protected time within their SPA allowance to progress these responsibilities, this time is embedded within their job plans.			**June 23**: All Consultant Surgeons with a lead role for quality and patient safety are enabled to retain protected time within their SPA allowance to progress these responsibilities, this time is embedded within their job plans.	31/03/2023
238	External	The National fraud Initiative in Wales 2020-21	Not Rated	Director of Finance & Procuement		N/A	R2) Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.	The key lead for the NFI in ABUHB has reviewed the NFI self-appraisal check-list and will ensure that they will remain fully informed of the progress of the NFI exercise.	TBC			Complete				Completed	None	As per management update	Completed	
239	External	The National fraud Initiative in Wales 2020-21	Not Rated	Director of Finance & Procuement		N/A	R3) Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.	To date there has been no plans for Internal audit to review the current processes in relation to timeliness for NFI. If it happens in the future any recommendations will be implemented.	TBC			Complete				Completed	None	N/A	Completed	
240	External	Equality Impact Assessments: more than a tick box exercise?	Not Rated	Director of Workforce & OD		N/A	•Public bodies should review their overall approach to Equality Impact Assessment considering the findings of this report and the detailed guidance available from the Equalities and Human Rights Commission and the Practice Hub		31/12/2023			Complete								

Internal Audit Progress Report

Audit, Risk and Assurance Committee

July 2023

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2023/24 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') to the July 2023 Audit, Risk and Assurance Committee (the 'Committee');
- provide details of amendments to the 2023/24 Internal Audit Plan;
- highlight the final position for the 2022/23 Head of Internal Audit Opinion;
- provide details of additional audit work that has been requested; and
- provide an overview of other activity undertaken since the previous meeting.

2. Progress against the 2022/23 Internal Audit Plan

We have now concluded our internal audit work for the 2022/23 Internal Audit Plan, with the following reports issued since the meeting of the Audit, Risk and Assurance Committee on 23rd May 2023.

Audit	Assurance Rating
Dementia Services	Reasonable
Integrated Wellbeing Networks	Reasonable
Mental Health Transformation	Reasonable
Infection Prevention and Control	Reasonable
Contract Management	Reasonable
Clinical Futures – Care Closer to Home	Not rated[1]

Due to extended testing, the reports below have been issued in draft, but are still continuing through the finalisation process, in accordance with our Audit Charter. Therefore, whilst we have incorporated the conclusions of our work into the 2022/23 Head of Internal Audit Opinion, the final reports will be formally reported during 2023/24.

Audit	Draft Rating
Putting Things Right	Advisory review
Review of Bank Office and Temporary Staff	Reasonable

Further information over the assurance ratings detailed above is included with Appendix B.

[1] This is a consolidated report of the following audits: Mental Health Transformation; Integrated Wellbeing Networks; and Neighbourhood Care Networks.

3. Progress against the 2023/24 Internal Audit Plan

There are 29 individual reviews in the 2023/24 Internal Audit Plan. In addition, our Specialist Services Unit (SSU) undertake assurance work over major capital projects.

We have commenced the following audit work from the 2023/24 Internal Audit Plan.

Safeguarding
Waiting List Management
Clinical Coding
Providing Care to Asylum Seekers and Refugees
Allegations against Staff Policy
IMTP
Intra-site Patient Transfers

The delivery profile of each audit is illustrated within Appendix A.

4. Summary of Findings

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main messages from the reasonable assurance reports issued since the last meeting on 23rd May 2023.

Dementia Services (reasonable assurance)

This audit examined the dementia services carried out by the Health Board, across a sample of wards. Overall, we found that the service is well designed and clearly reflected within processes and supporting documentation. There was also significant progress made to ensure that the processes complied with the newly introduced "All Wales Dementia Care Pathway of Standards", issued by the Welsh Government.

However, we identified several areas where actions are required to further improve dementia services. These include the following:

- the establishment of internal deadlines to deliver on the Standards;
- further embedding the enhanced care framework;
- improve the methods for recording patient data;
- set / monitor KPIs; and
- the sharing of best practice.

Following the fieldwork phase of the audit, we extended our testing further to assess the implementation of a sample of requirements within the Kings Fund Assessment Tool (appendix C of the audit report). We have also, for completeness, included an assessment against the Dementia Hospital Friendly Charter for Wales (appendix B).

Integrated Wellbeing Networks (reasonable assurance)

The audit sought to review the arrangements in place to improve and strengthen wellbeing within the community by utilising existing community assets. Overall, we found strong controls in place, with good governance of the Integrated Wellbeing Networks (IWNs) programme of work.

Whilst the overall report was positive, we recommended:

- that the approach to communicating and monitoring the plans should be formalised; and
- that success of the projects should be defined, to ensure the benefits are being achieved.

Mental Health Transformation (reasonable assurance)

This audit was undertaken to provide a review of the controls in place for the projects that support the transformation of mental health services within the Health Board.

We found that projects delivering mental health transformation are managed well, with oversight provided, depending upon the nature of individual contracts. Whilst governance is consistently embedded through the mental health transformation structures, it is also provided by other parties, both internal and external to the Health Board. There is a need for clarity on each project, regarding the allocation of such roles and responsibilities, to provide assurance that any gaps or duplication are identified and addressed.

We also raised the following findings:

- assurances provided by other parties should be supported by a periodic review; and
- there is a lack of a consistent process for the identification, discussion, reporting and tracking of significant matters for escalation, alongside further enhancement to Flash Project reporting.

Infection Prevention and Control (reasonable assurance)

The audit assessed the level of adherence to key policies and procedures throughout a sample of wards, regarding infection control.

Tests within this audit have been completed previously (2017-18, reasonable assurance). Within that audit, we identified non-compliances throughout the 17 wards tested, with a high priority recommendation raised.

However, whilst we identified exceptions within the sample tested during this audit, we found a more positive position overall.

Within Appendix B of the report, a summary over the level of compliance, across each of the 16 wards at four hospital sites, is included. The main non-conformances relate to:

- the storage of equipment;

- identification of equipment that has been cleaned, with the appropriate sticker; and
- the administration of the cleaning rotas.

Contract Management (reasonable assurance)

This audit examined the operational management of a sample of contracts entered into by the Health Board. Initially, we sampled three contracts, but extended this to five contracts, to further assess the embedding of processes within the Health Board.

Overall, we found that contracts are managed operationally on an individual level, as there is no defined policy or procedure in place. However, we determined that actions undertaken by managers were often in accordance with expected controls (e.g. contract meetings / performance monitoring). We found this to be the case across all contracts sampled.

There is an urgent need to define and communicate the process for managing contracts operationally, and to support this through training. We also recommended the introduction of contract risk registers, as part of the defined process and a shared repository of contract documentation.

Clinical Futures – Care Closer to Home (not rated)

This report is a consolidated summary of audit work completed of Clinical Futures – Care Closer to Home, but from three other audits encompassing this area. Overall, testing regarding care closer to home was a significant portion within the following audits: Mental Health Transformation; Integrated Wellbeing Networks; and Neighbourhood Care Networks (NCNs).

In particular, we found that two key plans to deliver care closer to home relate to the role of NCNs and the mental health transformation work underway.

In summary, we did not raise any specific areas of concern, other than the recommendations within each of the three audit reports (each rated reasonable assurance) detailed above. This forms the basis of the consolidated report. Overall, we found that:

- there are effective processes in place for tracking the progress of key projects being implemented, to deliver the Health Board's objectives and that these are reported to, and monitored by, appropriate bodies;
- projects and plans address time, cost, benefits and quality targets, as appropriate, and that there is an effective structure defining roles and responsibilities for project / plan delivery; and
- there are procedures and structures to ensure that any significant issues identified within the monitoring process are escalated and corrective actions implemented / monitored.

However, we did recommend within the:

- NCN audit that a review of the governance arrangements for planning and delivery would be beneficial, together with a review of the workforce plans; and

- Mental Health Transformation audit, that where reliance is placed on third parties or assurance is provided that this is reviewed further. Furthermore, we raised a recommendation to improve the process for matters for escalation, via the Flash Reporting process.

4. 2022/23 Head of Internal Audit Opinion

The final 2022/23 Head of Internal Audit Opinion and Annual Report is presented for review and noting the final opinion rating.

As previously highlighted, the Head of Internal Audit opinion is reasonable assurance and is based on the outcome of work from the 2022/23 Internal Audit Plan and other relevant information or knowledge regarding the Health Board.

5. 2023/24 Internal Audit Plan

Amendments to the 2023/24 Internal Audit Plan

We have commenced the planning work for the audit of Job Planning, scheduled for quarter two. However, during the scoping meeting, we were requested to defer the audit until quarter four onwards.

Whilst the Plan has only recently been approved, we recognise that there is an ongoing implementation of job planning related actions. This work is still in progress and thus, not yet complete.

We propose to deliver the audit work during quarter four, but to update the outline scope to focus the review on the delivery and management of the implementation plan instead.

Additional Audit Work Requested within the 2023/24 Internal Audit Plan

We have received a formal request for one additional audit and a request for another possible review to be considered for inclusion within the 2023 / 24 Internal Audit Plan and if approved, to be completed as a priority. These are:

- a formal request for an audit of the Health Board's financial governance arrangements relating to the Regional Partnership Board; and
- a possible review of the controls in place for the approval of rosters (other related documentation) within the Facilities Division.

Whilst we will liaise with the respective Lead Executive(s) to develop the scope of each review, there is flexibility to utilise some or all of the audit days from the Regional Partnership Board audit, scheduled for quarter four for the first request listed.

Therefore, we are seeking **consideration and approval** for the above amendments to the Plan and the Plan updated to incorporate up to two additional audit reviews.

6. Other Activity

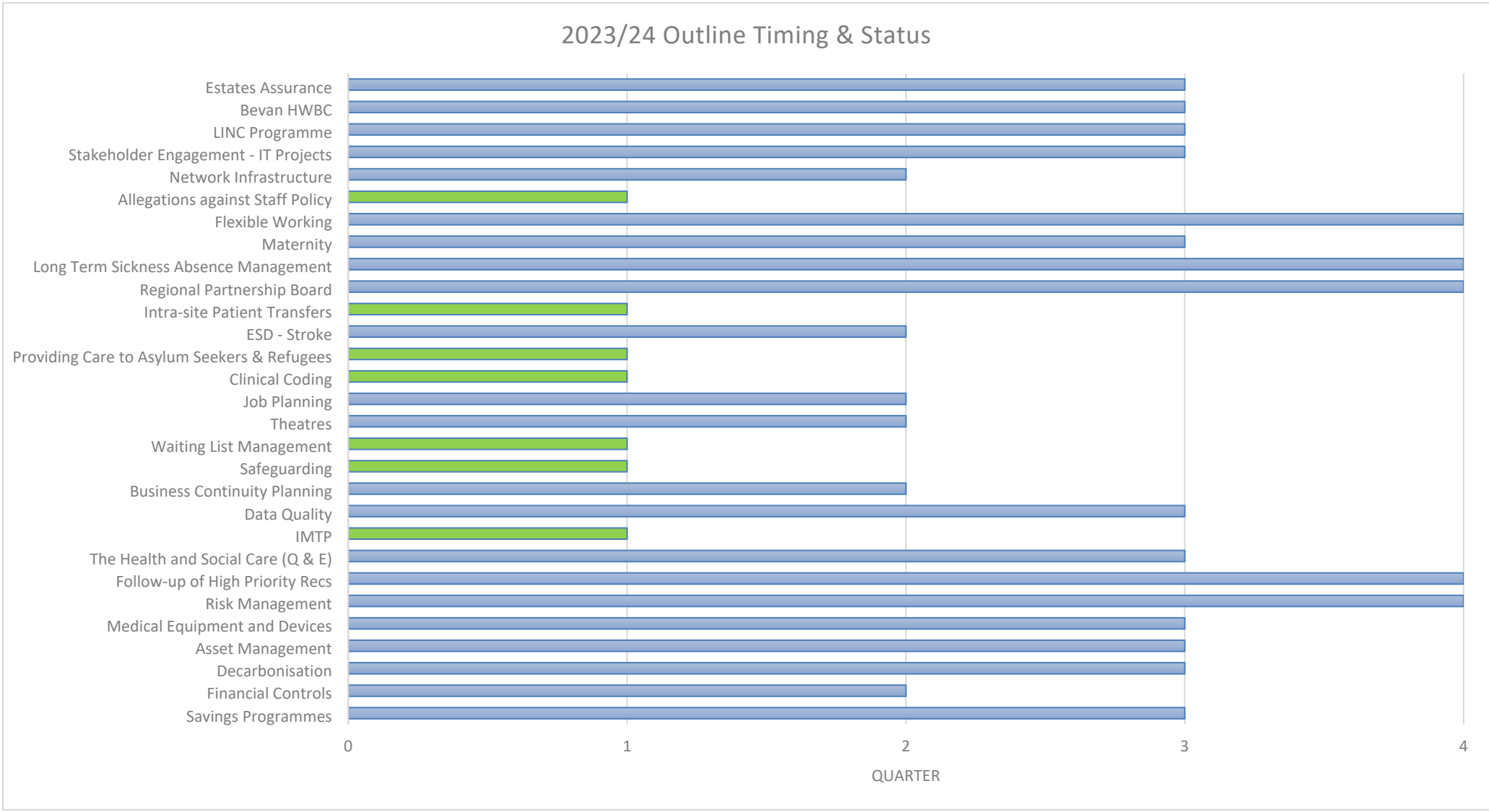
The following meetings have been held/attended during the reporting period:

- monthly meetings with the Director of Corporate Governance;
- monthly meetings with the Director of Finance, Procurement and Value;
- Audit, Risk and Assurance Committee pre-meeting with the Audit, Risk and Assurance Committee Chair;
- review and advice over financial control procedures; and
- liaison with senior management.

7. Recommendation

The Audit, Risk and Assurance Committee is invited to, **approve** the Internal Audit Plan amendments, **approve** the additional audit work requested and **note** the above points within the report.

Appendix A: Progress against 2023/24 Internal Audit Plan



Appendix B: Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Clinical Futures - Care Closer to Home

Consolidated Internal Audit Report

July 2023

Aneurin Bevan University Health Board

Contents

Review reference:	AB-2223-04
Final report issued:	27th June 2023
Auditors:	Stephen Chaney, Acting Head of Internal Audit Philip Lewis-Davies, Principal Auditor
Lead Executive:	Hannah Evans, Director of Strategy, Planning and Partnerships
Distribution:	Chris O'Connor, Divisional Director of Primary Care, Community and Mental Health
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

This report provides Aneurin Bevan University Health Board (the 'Health Board') with a consolidated summary of audit work reported as part of the 2022/23 Internal Audit Plan that covers the area of Clinical Futures – Care Closer to Home. In particular, whether the Health Board is on track to implement its overall objective of Care Closer to Home.

We have considered the objectives of the following audits completed, notably:

- Mental Health Transformation (reasonable assurance);
- Integrated Well-being Networks (IWN) (reasonable assurance); and
- Neighbourhood Care Networks (NCN) (reasonable assurance).

Overview

As this report is a summary document of audit work that has been completed as part of other audit assignments, we have not assigned an overall assurance rating. However, each of the audits completed were rated as reasonable assurance.

We found that the objective of Care Closer to Home is embedded in all projects/plans incorporated in all three areas considered in the above audits and that their management and oversight in place are supportive of the delivery of improved services that can be accessed by patients within their communities, either physically or virtually.

No detailed findings have been raised in this audit report.

Report Classification for each Audit

Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

1. Mental Health Transformation
2. Integrated Well-being Networks
3. Neighbourhood Care Networks

1. Introduction

1.1 As part of the 2022/23 Internal Audit Plan (the 'Plan') we planned to deliver the Clinical Futures: Care Closer to Home audit. However, as we progressed through the delivery of Aneurin Bevan University Health Board's (the 'Health Board') Plan, we assessed this area multiple times within other audits. Therefore, we have consolidated our conclusions, findings and assurance ratings to provide a summary report.

1.2 The Health Board's Integrated Medium-Term Plan (IMTP) for 2022/23-2024/25 comments that the Clinical Futures Strategy has remained resilient and relevant for over a decade. The opening of the Grange University Hospital (GUH), as part of a new hospital network, was a fundamental milestone in the delivery of the broader strategy. However, Clinical Futures is about much more than one hospital; it seeks to improve population health, resilience and well-being and to deliver care closer to home, primarily thorough primary and community services, all supported by a hospital network.

1.3 The Health Board's approach in 2022/23 has been to continue to embed the new models of care that could not be fully implemented whilst the system responded to the pandemic. However, the Health Board's focus and key opportunities for achieving a sustainable system lie in delivering the broader strategy and strengthening the role of the Enhanced Local General Hospital (eLGH) network and the provision of more care closer to home solutions.

1.4 The Health Board has reshaped the Clinical Futures Programme to support the delivery of the organisation's key priorities delivering the biggest impact on improving the sustainability of the system.

1.5 This consolidated report incorporates the relevant conclusions from the following audits:

- Mental Health Transformation (reasonable assurance);
- Integrated Well-being Networks (IWN) (reasonable assurance); and
- Neighbourhood Care Networks (NCN) (reasonable assurance).

1.6 We have summarised our conclusions under three separate headings, including Project Delivery, Roles and Responsibilities and Issue Management.

2. Consolidated Audit Findings

Project Delivery

2.1 Within the Mental Health Transformation audit we reviewed two key transformation projects. Both projects, Shared Lives and Mental Health 111, have incurred staged developments offering care solutions closer to home. The projects were found to be effectively controlled during the project development and implementation with oversight provided by mental health transformation

governance structures. Each project is now migrating to business as usual following successful development and implementation stages.

2.2 We found that whilst governance is consistently provided throughout the mental health transformation structures, it may also be provided by other parties, both internal and external to the Health Board. There is a need for clarity on each project regarding the allocation of such roles and responsibilities to provide assurance that any gaps or duplication are identified and addressed.

2.3 Integrated Well-being Networks (IWN) aim to improve and strengthen wellbeing, by connecting and enhancing community assets for people. This includes the development of community based hubs able to provide care closer to home.

2.4 As part of the IWN audit we concluded that there are governance arrangements of the IWN programme in place, with numerous levels of monitoring across the Health Board and other partners. We noted that a more formalised approach is in the process of being developed, with a draft terms of reference for an advisory group, to identify a more effective way to analyse the success of IWN projects already in place.

2.5 Neighbourhood Care Networks (NCNs) are vehicles for delivering patient focused change across each locality. This is achieved through individual integrated medium-term plans (IMTP), which also incorporate the principles of the Primary Care Model for Wales and the Strategic Programme for Primary Care, again focusing on the delivery of care closer to home.

2.6 There is a close working relationship between the IWN and NCN programme. The Service Development Lead (SDL) and a Community Involvement Officer (CIO) for each IWN local authority region maintain links with their respective NCN teams. Working with the 11 NCNs, local authority and third sector, IWNs have sought to support the delivery of more 'care closer to home'.

2.6 As part of the NCN audit we commented that individual NCNs meet on a quarterly basis. Attendance at the meetings includes representatives from the GP practices within each NCN, as well as staff from the Health Board.

2.7 However, we noted that a review of its structure would be beneficial and management responded commenting that the Primary Care and Community Service Division has sponsored a report to the Regional Partnership Board (RPB) regarding a suitable governance structure for NCN planning and delivery, whilst still meeting key milestones.

Conclusion:

2.8 We found that there are effective processes in place for tracking the progress of key projects being implemented to deliver the Health Board's objectives and that these are reported to, and monitored by, appropriate bodies.

Roles and Responsibilities

2.9 We found that for the two key mental health transformation projects reviewed that the Shared Live project had adopted the Health Board's business case process and had defined key targets within the supporting documentation. Regarding the Mental Health 111 project, this was not the case as the project was aligned to the national project work underway and thus, this was not appropriate to do so. Whilst both projects addressed time, cost, benefits and quality targets we commented on the need for the Health Board's mental health transformation governance structures to assess any reliance placed on third parties.

2.10 Each IWN local authority region has an SDL and a CIO. The role of the CIO is to engage with the community and understand what the needs of that community are and how best to support the local population. Together they focus on delivering projects of need for their community. Each of the IWN SDLs develop an annual plan for targeting priorities and programmes / projects for the upcoming financial year.

2.11 Within the NCN audit we noted that workforce plans are minimal and do not provide much detail. This is a weakness already understood by the Health Board. This year the Health Board has access to the National Workforce Reporting System which provides detailed information at a GP practice and an NCN level. This will inform future planning and was discussed at the Board Development session during October 2022. However, more detailed workforce plans are yet to be completed and management have commented that newly appointed personnel within the NCN Office will support the NCN Leads and locality teams to develop workforce plans.

Conclusion:

2.12 We found that projects and plans address time, cost, benefits and quality targets, as appropriate, and that there is an effective communicated structure defining roles and responsibilities for project / plan delivery.

Issue Management

2.13 Within the Mental Health Transformation audit we noted that whilst significant matters identified are discussed at Whole Person Whole System Crisis Support Programme and at the Mental Health Transformation Board, there is a need to clarify the process and to include how such matters are captured and managed, where other organisations are engaged and providing separate oversight.

2.14 We also noted the recent development of Project Flash reporting and commented on further improvements to its compilation and use, regarding the reporting of matters for escalation.

2.15 Regarding IWNs, the Specialty Registrar for the Public Health Team holds monthly sessions with the Service Development Leads. The meetings are documented and detail what has gone well and what challenges there have been within each of the IWN communities.

2.16 The Senior Management Team for Public Health is provided with regular updates on the IWN programme. We also reviewed the exception reporting process, where we confirmed that this allows an opportunity for a full focus on the most significant risks and issues to the IWN programme to be discussed and addressed.

2.17 The NCNs meet every quarter and from our review of the minutes we noted that at each meeting a wide variety of topics were reviewed, including actions raised as part of the last meeting to track progress, the sustainability of services; and updates on projects that are currently underway.

2.18 NCN clinical leads meetings are also held. We observed one of these meetings and confirmed the forum is used by the Health Board to discuss topics which affect all NCNs. These structures provide an opportunity to escalate matters from the NCNs to the Health Board.

Conclusion:

2.19 We found that procedures and structures existed to ensure that any significant issues identified within the monitoring process are escalated, corrective actions are agreed, and their implementation effectively monitored.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Infection Prevention and Control
Final Internal Audit Report

June 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Auditors:	Stephen Chaney, Acting Head of Internal Audit Laura Howells, Principal Auditor
Executive sign-off:	Jennifer Winslade, Executive Director of Nursing
Distribution:	Tracey Partridge-Wilson, Assistant Director of Nursing Deb Jackson, Assistant Director of Nursing, IPC Moira Bevan, Head of Infection Prevention and Control
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To assess adherence to organisational policies and the Health and Care Standards in Wales.

Overview

We have issued reasonable assurance on this area.

Overall, there was good compliance with the Health Board's Infection Prevention and Control (IPC) policies. Where non-compliance was identified these were isolated instances rather than an underlying failure of controls embedded.

The matters requiring management attention include:

- Some examples of non-compliance with IPC processes during our ward sample testing.

Other recommendations / advisory points are within the detail of the report.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔

Assurance summary[1]

Assurance objectives	Assurance
1 IPC assurance	Substantial
2 Infection control	Reasonable

Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 IPC Policy Compliance	2	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The review of Infection Prevention and Control (IPC) was completed in line with the 2022/2023 Internal Audit Plan. IPC is fundamental in ensuring the provision of a safe environment for staff and service users.

1.2 IPC is the responsibility of all Health Board staff, with divisions being responsible for ensuring IPC management within their areas. The Health Board's IPC Team is a specialist resource providing advice and education to all disciplines of staff so that everyone is aware of the importance of infection control. Within this role the team support the wards by recommending how to improve environments and help to ensure a low risk of cross infection.

1.3 The key risks considered in this review were non-compliance with IPC processes and best practice, potentially resulting in:

- patient harm or poor patient experience;
- extended hospital stays impacting on the effective use of patient facilities;
- financial loss; and
- reputational damage.

1.4 As part of this review, we completed ward testing at four different Health Board sites, covering 16 wards. The number of wards and hospitals visited are noted below:

Grange University Hospital: Wards – A0, C0, C1, C4, NICU/SCBU

Royal Gwent Hospital: Wards – D3 West, C7 West, D3 East, D4 West, D2 West

Nevill Hall Hospital: Wards – 4/2, 4/3, 3/1, EAU

Ysbyty Ystrad Fawr: Wards – 2/2 Bargoed, Ty Glas

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	1	-	1
Total	-	1	-	1

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: The Board receives assurance over IPC risks (including any residual risk from the pandemic), with scrutiny of performance at the appropriate forums. This includes the management of IPC outbreaks e.g. Clostridium difficile (C.diff) and MRSA.

2.3 The Health Board has in place, the Infection Prevention and Control Policy (the 'Policy') which sets out the IPC principles and responsibilities of all staff. The Policy is in date and available to staff via the intranet. Throughout the audit we interviewed staff and found a good level of awareness of the Policy and the responsibilities therein.

2.4 The Policy states that infection prevention is monitored throughout the Quality and Patient Safety Assurance Framework. The Chief Executive accepts on behalf of the Board ultimate responsibility for all aspects of infection prevention and control. The Director of Nursing accepts delegated responsibility for infection control.

2.5 IPC update reports are prepared and shared with the Quality and Patient Safety Operational Group (QPSOG) for review and action, where required. The Head of IPC reports on multiple IPC areas and always includes C. diff data. In March 2023, it was reported that for the months of November and December 2022 there had been 8% fewer cases of C. diff compared to the previous year.

2.6 Unresolved IPC issues from the QPSOG are escalated to the Patient Quality, Safety and Outcomes Committee (QPSOC). In addition, an update report is sent to the QPSOC for review and covers items discussed by the QPSOG. This report includes data on the current position of a variety of infections including:

- E. coli;
- C. diff;
- Klebsiella;
- Staph aureus; and
- Pseudomonas.

It also details any wards that are under observation for IPC issues.

2.7 An annual report for IPC is also produced. The draft IPC annual report for 2022/23 has been completed and once finalised will go to the PQSOC. The annual report provides an overview of themes and learning, including performance and assurance regarding the following:

- Infection Prevention Team and governance arrangements;
- Welsh Government Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HAI) Improvement Goals;
- Respiratory infections (Covid-19, Influenza, Respiratory syncytial virus (RSV);
- Covid Investigation Team;
- Decontamination strategy; and
- Infection prevention incidents.

Conclusion:

2.8 There are robust controls in place for the monitoring of IPC performance and for providing assurance to the Board. Therefore, we have provided substantial assurance over this area.

Audit objective 2: Key elements of standard Infection Control Precautions are adhered to, including:

- patient placement;
- hand hygiene;
- management of care equipment; and
- safe disposal of linen and clinical waste.

2.9 We undertook IPC ward testing across the 16 different wards, as noted within 1.4. From this ward testing we have compiled a list of observations and RAG rated (red through to green) the overall compliance for each IPC area. A summary of the key themes is provided below.

2.10

IPC area	Observations	Compliance
Patient Placement	This IPC area was the least adhered to from all areas tested. There was generally compliance with PPE and keeping areas clear of spills, but we identified some exceptions too. There was a theme that cleaning rotas were often not fully completed. Through discussion with staff and observation on site, we noted that this was typically an administrative omission of them not being signed, rather than the cleaning not being completed. Furthermore, we noted that the toilet areas of every ward except for Nevill Hall: wards - 3/1, EAU and GUH: wards - C1, NICU/SCBU had cleaning compliance issues. These issues were not with the cleanliness of the toilet / bathroom facilities themselves, but rather other minor related matters. Spot checks of the toilets between their designated cleaning schedules would help alleviate these instances. We also identified an issue with more than one of the toilets at three wards visited at the Royal Gwent Hospital, with either the flush not working or the toilet being out of service.	

Hand Hygiene	We observed the hand hygiene process adopted by ward staff when in contact with patients. We did not identify any areas of concern. We also confirmed that there were multiple areas for hand cleaning throughout each ward, with each filled with hand gel / soap.	
Care Equipment	We concluded that storage space was a particular issue for equipment on every ward. We identified instances of equipment stored in corridors within our sample tested. Staff informed us that specific equipment was used so frequently that there would rarely be a chance for the equipment to be stored, as it was in continuous use. Other wards used a specific area at the end of their ward to store equipment that could not fit into the limited storage space. We noted these were areas where patients did not venture and was the most appropriate solution to the lack of storage.	
Waste Disposal	Each ward had multiple sharps boxes (disposal of syringes). We identified several instances where sharps boxes were filled over their capacity line. However, we did not identify any instances where a sharps box was overflowing. We did not identify any bins overflowing with waste during our ward testing. The area of largest non-compliance was at the Grange, where three wards had one bin that was over ¾ full, but still within capacity. We reviewed multiple bins on each ward and generally saw good compliance.	
Other observations	We noted that most wards did not recycle. The Welsh Government has set recycling targets, which the Health Board will need to meet in the upcoming years and so it would be prudent to begin to address these issues. Furthermore, we noted that there were no instructions on what can (and what can not) be disposed of in each bin, on most of the wards identified. Although staff were aware of what waste should be disposed in each bag, due to different colour waste bags, we noted that the public would not be aware and instructions on the bins would prevent any patients accidentally disposing of waste in the incorrect bin.	N/A

2.11 Staff on site were welcoming and had good knowledge of IPC controls. Many staff recounted the impact of the pandemic on their approach towards infection prevention and control, with it often at the forefront of their daily routines. Furthermore, a number of staff noted how the continuous IPC audits carried out internally by the Health Board had ensured a good standard of IPC was maintained.

2.12 There were examples of non-compliance within the wards sampled, but staff on site were keen to resolve these individual issues whilst we were on site, e.g. ensuring dirty toilets were cleaned. However, we have raised this as matter arising one.

2.13 For ease of reference, a summary of all testing conclusions across all wards sampled is included within Appendix B.

Conclusion:

2.14 Overall, there was compliance with the Policy, but we identified instances of non-compliance on the wards sampled. Therefore, we have given this area **reasonable assurance**.

Appendix A: Management Action Plan

Matter arising 1: IPC compliance (Operation)	Impact
We undertook testing of infection prevention and control procedures across a sample of wards. In total, we completed 20 tests across 16 wards encompassing waste management, the care of equipment, environmental factors for the placement of patients, hand hygiene and the cleanliness of key patient ward facilities. Detailed testing ward conclusions are presented in Appendix B. We identified the following non-compliances: • the storage of equipment – where it is often located in a corridor; • ten wards where the use of 'I am clean stickers' are not always present on clean equipment (e.g. commodes); • the cleaning rotas were not always fully completed; • a couple of instances of broken toilets (e.g. not flushing); • sharps boxes were overfilled past the capacity line on eight wards; and • other matters identified (e.g. broken curtain, lingering smells and waste labels not present on bins).	Potential risk of: • patient harm or poor patient experience through poor IPC • financial and reputational damage

Recommendations	Priority
1.1 Management should undertake a walk around / review of wards covered in this audit to ensure areas of non-compliance have been addressed. Any lessons to be learnt should be shared with the remaining wards to ensure compliance throughout the Health Board.	Medium

Management response	Target Date	Responsible Officer
1.1 Email circulated to Divisional Nurses on the 30.05.23 asking for the above recommendation to be implemented and update via local quality and patient safety forums and the Reducing Nosocomial Transmission Group. Dashboard audits are available on the AMaT platform.	July 2023	Moira Bevan

Appendix B: Audit Testing Summary

Hospital	Ward	Spillage	Cleaning rota	Shower / toilet	Cleaning Facilities	Equipment Storage	' Clean' Stickers	Waste Disposal	Bin Capacity	Sharps Boxes	Worktops	Special Rooms	Environment
GUH	A0												
	C0												
	B1/C1												
	C4												
	NICU / SCBU												
RGH	D3 West			2									
	C7 West			1									
	D3 East			1									
	D4 West												
	D2 West												
Nevill Hall	4/2												
	4/3												
	3/1												
	EAU												
YYF	2/2 Bargoed												
	Ty Glas												

Numerous compliance issues	Some compliance issues	None/minor compliance issues

1 - These areas were RAG rated yellow due to malfunctioning /broken toilets and not due to cleanliness issues.

2 - This area had cleanliness issues as well as a broken toilet

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Integrated Wellbeing Networks
Final Internal Audit Report

June 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
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Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Distribution:	Stuart Bourne, Deputy Director of Public Health - Population Health Improvement Will Beer, Consultant in Public Health Jonny Currie, Specialty Registrar for Public Health
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

To provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region.

Overview

We have issued reasonable assurance on this area.

The Integrated Wellbeing Networks (IWN) programme is well governed and there are plans in place to support the development of integrated, place based, well-being systems across the Gwent region.

The matters requiring management attention include:

- Formalising the approval process for local annual IWN plans; and
- Formalising the process for reviewing the success of IWN projects.

Other recommendations / advisory points are within the detail of the report.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Assurance objectives	Assurance
1 IWN Plans	Reasonable
2 Governance	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IWN annual plans	1	Design	Medium
2	Defining success	2	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The internal audit of Integrated Wellbeing Networks (IWNs) was completed in line with the 2022/23 Internal Audit Plan. IWNs aim to improve and strengthen wellbeing, by connecting and enhancing community assets for people. There are four elements in relation to this:

1. Place-based collaboration;
2. Community-based hubs;
3. People who deliver services and support; and
4. Easy access to well-being information.

1.2 IWNs currently operate in selected areas within Blaenau Gwent, Caerphilly, Newport, Monmouthshire and Torfaen with work in those areas tailored to local priorities.

1.3 As part of other planned audit work we have already considered neighbourhoods care networks (NCNs) and mental health provision through the following reviews: Neighbourhood Care Networks; Mental Health Transformation; and Clinical Futures: Care Closer to Home.

1.4 Risk considered as part of this review were:

- insufficient progress with planned actions;
- a lack of sound governance arrangements, thus preventing the achievement of planned objectives; and
- strategic objectives are not achieved in a timely manner.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	-	2
Operating Effectiveness	-	-	-	-
Total	-	2	-	2

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

2.3 IWNs are aligned to small towns or areas within a larger city and enable people to find support when they need it and strengthen community capacity, supportive social networks and assets. Below is a list of the current IWN communities:

Local Authority	IWN Communities
Newport	Pillgwenlly & Ringland
Torfaen	Blaenavon, Croesyceiliog & Llanyrafon
Blaenau Gwent	Brynmawr & Tredegar
Caerphilly	Rhymney, New Tredegar, Bargoed & Risca

Audit objective 1: Plans are in place to support the establishment of integrated, place based, well-being systems across the Gwent region (including mental health provision).

2.4 Each IWN local authority region has a Service Development Lead (SDL) and a Community Involvement Officer (CIO). The role of the CIO is to engage with the community and understand what the needs of that community are and how best to support locals. Together they focus on delivering projects of need for their community. The programmes / projects completed are in line with the four objectives of the overarching IWN programme.

2.5 Each of the IWN SDLs develop an annual plan for targeting priorities and programmes / projects for the upcoming financial year. We reviewed the plans and confirmed that they are in line with the four main objectives of the IWN programme, as set out in the introduction. Currently, plans are approved by the Specialty Registrar for Public Health, but a more formalised approach is planned to be undertaken in the future. **Matter arising 1.**

2.6 There is a close working relationship between the IWN and NCN programme. The SDL and CIO for each IWN local authority region maintain links with their respective NCN teams. Working with the 11 NCNs, local authority and third sector, IWNs have sought to support the delivery of more 'care closer to home'.

2.7 A collaborative in each area has been set up to encourage statutory and community partners to network and work. Regular meetings of the collaborative are held, and these meetings are chaired by the SDL responsible for that IWN. When the SDL is unavailable, the meetings are not held, thus creating a single point of failure. **Matter arising 1**.

Conclusion:

2.8 There are plans in place clearly linked to the main objectives / goals of the IWN programme which in turn support development of a whole system approach to community wellbeing and prevention that brings together a wide range of wellbeing assets. Therefore, we have given **reasonable assurance** to this area.

Audit objective 2: Appropriate governance arrangements are embedded for monitoring the progress and implementation of actions to deliver healthy communities.

2.9 The IWN programme is monitored in a variety of ways. The Specialty Registrar for the Public Health Team holds monthly sessions with the Service Development Leads. The meetings are documented and detail what has gone well and what challenges there have been within each of the IWN communities and how best to progress to meet the objectives of the programme.

2.10 The Senior Management Team for Public Health is provided with regular updates on the IWN programme, through exception reporting. This allows an opportunity for a full focus on the most significant risks and issues to the IWN programme to be discussed and addressed.

2.11 There are fortnightly meetings between the SDLs, CIOs, consultant lead and business support officer. This forum allows a space for all of the SDLs to come together to understand what projects are working well in each of their IWN areas. From interviews with the SDLs, we noted that the leads find these meetings particularly helpful in providing a place to collaborate and provide inspiration for projects.

2.12 Currently, data on the success of IWN projects in each area is predominately collected informally and analysis is usually discussed between the SDL, CIO and their respective communities. For example, through comments from the public at meet and greet sessions. A more formalised approach is in the process of being developed with a draft terms of reference for an advisory group to identify a more effective way to analyse the success of projects already in place. **Matter arising 2**.

2.13 The Covid-19 pandemic significantly stalled the IWN programme. The programme is still progressing with the initial areas identified as in most need. Development of the parameters of 'what success looks like' for the IWN programme should allow for a more targeted approach to the projects and third-party relationships. This should in turn allow the IWN programme to branch out and focus on other areas of need in their communities.

Conclusion:

2.14 There are governance arrangements of the IWN programme in place, with numerous levels of monitoring across the Health Board and other partners. Further development of how to analyse success of projects will allow the programme to progress further. Therefore, we have given this area **reasonable assurance**.

Appendix A: Management Action Plan

Matter arising 1: IWN plans and support (Design)	Impact
Each of the IWN community Service Development Lead (SDL) create an annual plan, which identify areas they wish to target and programmes / projects they plan on running for the upcoming financial year. Currently, plans are approved by the Consultant Lead for the programme in the Local Public Health Team. There are plans to create an IWN leadership group with representation from all five local authorities and potentially other Gwent partners to expand the leadership of the programme to a more distributed/collaborative structure. This may be an appropriate group to sign off the IWN plans, to enable more collaborative plans. When the SDL is unavailable, the local IWN collaborative meetings are not held, thus creating a single point of failure. We were informed that a new programme manager role for the IWNs had been developed and it is anticipated they would be able to provide the cover should the need arise.	Potential risk of: • IWN programmes not progressing due to absences • Plans not being sufficiently scrutinised

Recommendations	Priority
1.1 Management should formalise the approach to communicating/monitoring local IWN plans and providing cover if the Service Development Lead is absent.	Medium

Management response	Target Date	Responsible Officer
1.1 The strategic development plan for the IWN programme for 2023/24 has identified a need for the Distributed Leadership Group, with representation from each local authority and the Community Voluntary Councils in Gwent; it is anticipated this will enable shared ownership of the IWN programme between agencies and for the IWN's place-based agenda to become more embedded in the delivery plans of partnership agencies. Alongside this, Regional Partnership Boards have now created in Gwent 5 Integrated Partnership Service Boards (ISPBs), in each local authority area, responsible for strategic and service planning between health, local authorities and the third sector. With the IWN programme and officers now embedded in these ISPBs, the programme seeks from 2024/25 onwards for local IWN wellbeing plans to be approved by ISPBs to ensure robust governance and approval.		

The development of place-based wellbeing plans in each of the collaborative areas, in which the IWN programme works, has to date been led by our Service Development Leads (SDLs), in partnership with the place-based collaborative members. Plans are developed locally based on feedback and direction from community and collaborative members. We will ensure the plans are shared with the new IWN Distributed Leadership Group.	01/04/2024	IWN Programme Manager
Community Involvement Officer colleagues are often able to deputise in the absence of the SDL. The programme will explore sharing meeting facilitation with community partners and with the appointment of an 8b Programme Manager (currently out to advert) how the programme can support local meeting facilitation and programme delivery where SDL colleagues are absent for prolonged periods.	31/08/2023	IWN Programme Manager

Matter arising 2: Defining success (Design)	Impact
Data on the success of IWN projects in each area is predominately collected informally and analysis is usually verbally between the Service Development Lead (SDL), Community Involvement Officer (CIO) and their respective communities. For example, through comments from the public at meet and greet sessions. In addition, whilst indicative milestones are included within the individual plans, there are no specific delivery targets and / or success criteria included. A more formalised approach is in the process of being developed with a draft terms of reference for an advisory group, to identify the more effective way to analyse the success of projects already in place.	Potential risk of: • Projects may be run that do not provide the expected benefit to the local community • Parameters for success are not identified which stagnates the programme and prevents its growth in other, at need areas.

Recommendations	Priority
2.1 Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations.	Medium

Management response	Target Date	Responsible Officer
2.1 An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for	31/10/2023	IWN Programme Manager

IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023.

The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Appendix C – How Integrated Well-Being Networks Operate

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Dementia Services
Final Internal Audit Report

June 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Auditors:	Stephen Chaney, Acting Head of Internal Audit Krisztina Kozlovszky, Internal Audit Manager
Executive sign-off:	Jennifer Winslade, Director of Nursing
Distribution:	Chris O'Connor, Director of Primary Care, Mental Health & LD Tanya Strange, Head of Nursing Person Centred Care Michelle Forking, Divisional Nurse for Mental Health &LD Amanda Whent, Lead Nurse Dementia
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To ensure that Aneurin Bevan University Health Board (the 'Health Board') has an appropriate process for Dementia Services.

Overview

We have provided **reasonable assurance** over this area.

Dementia Services are carried out by the Health Board, are well designed and clearly reflected within the Hospital Charter. The organisation also made significant progress to ensure that they comply with the newly introduced "All Wales Dementia Care Pathway of Standards" issued by the Welsh Government.

However, we identified several areas where actions are required to further improve dementia services. These included the following areas:

- establish internal deadlines to deliver on the Standards;
- further embedding the enhanced care framework;
- improve the ways on how patient data is recorded;
- set / monitor KPIs; and
- sharing best practice.

The above points are detailed further in Appendix A.

Report Classification

		Trend
Reasonable assurance 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A Not audited separately previously

Assurance summary[1]

Assurance objectives		Assurance
1	Policies / procedures	Reasonable
2	Identification and documentation	Limited
3	Monitoring and reassessment	Reasonable
4	Environment	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Internal deadlines	1, 4	Operation	Medium
2	Internal spot checks	1	Operation	Medium
3	Structured electronic records	2, 3	Design	Medium
4	Use of alerts	2	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board') a review of Dementia Services was undertaken.

1.2 In 2013, there were an estimated 45,529 people living with dementia in Wales, of those people, only 17,661 had received a formal diagnosis. Within the Health Board's region there are approximately 8,000 people living with dementia.

1.3 The Regional Dementia Strategy was launched during the summer of 2018. The priority actions identified in this regional action plan are informed by the views of local people.

1.4 As part of our review, we visited 15 wards across seven hospitals (NHH, RGH, YYF, YAB, St Woolos, County Hospital, Ysbyty'r Tri Chwm). This included 12 general wards and three mental health wards. For each ward we selected three patients with dementia and reviewed their records (except Rowan ward at County Hospital, where there were only two patients with dementia at the time of the visit, and one of them we had already selected at RGH, prior to a transfer). In total, we reviewed 43 patient records.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	5	8
Operating Effectiveness	-	2	2	4
Total	-	5	7	12

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: Policies / procedures – appropriate policies and procedures are in place to support dementia services

2.3 The Welsh Government (WG) has launched a Dementia Action Plan for Wales 2018-2022 (the 'Plan'). The Plan sets out a clear strategy for Wales to become a dementia-friendly nation that recognises the rights of people with dementia to feel valued and live as independently as possible in their communities. The Plan includes a timetable and a list of actions that are required to be delivered by the Health Board and other organisations in Wales.

2.4 The WG also issued an All Wales Dementia Care Pathway of Standards (the 'Standards'), which consists of 20 standards, with a delivery framework for the region across Wales covering the period of 2021-2023. In the first year, the key

aim was to support and assist to undertake engagement coproduction, scoping, readiness, and self-assessment. During the second year, the main focus is on implementation of the Standards into practice. We were able to confirm that there is a formal implementation plan in place to ensure compliance with these new Standards going forward. However, we have raised a recommendation to formalise internal delivery timeframes of all of the requirements set out. This has been raised as matter arising one.

2.5 We note that the Health Board has also adopted the "Dementia Friendly Hospital Charter for Wales", published in April 2022. We assessed some of the requirements included within this document and our findings are presented within Appendix B.

2.6 A new Person-Centred Enhanced Observation Framework (the 'Framework') for cognitive impaired patients was launched in 2022. This framework is not limited to patients with dementia patients, but often utilised for them. The Framework utilises a traffic light approach to determine the necessary care for patients. While there are templates in place to help with the use of the Framework, we saw numerous examples of staff still utilising the previous process.

2.7 We were informed that regular enhanced care audits are required to be carried out at each ward. As part of these audits, the nurses are required to complete spot checks and an "Enhanced Care Audit Tool" template for monthly peer review, and three monthly senior leadership review purposes. We found no evidence of the reviews taking place at the wards that we visited. This has been raised as matter arising two in Appendix A.

2.8 Furthermore, we found that the "this is me" document was not widely utilised across the Health Board, despite a reference made to it in the Framework. Whilst the document is required to be completed by the family, it is often undertaken in conjunction with a health care worker. At four wards we found that the document was on file. However, some of them were blank or only partially filled in. This has been included within matter arising two in Appendix A.

Conclusion:

2.9 We identified recommendations relating to implementing the Standards requirements, including the Hospital Charter and lack of internal spot checks related to the new enhanced observation framework. However, we did see progress towards the implementation of the Hospital Charter at many wards. This objective is linked to the work completed within audit objective four. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: Identification – patients with dementia are formally identified and the results are documented, with up-to-date records maintained

2.10 As part our review, we visited 12 general wards and three mental health wards and reviewed 43 patients' records. A summary of our findings is detailed below.

Electronic data !	<u>General Wards</u> Patients' electronic records are recorded in Clinical Workstation (CWS), this includes directly typed in entries and up-loaded documents. While the records are structured, the system does not have a dedicated place for dementia notes or related assessments, as such, the filing varies. CWS has an option to put an alert on certain patients. However, we found that only 8.82% (3 patients) of the reviewed dementia patients (34 patients) had dementia related alerts. We found that in most cases the alerts were used to highlight COVID cases. We were also told that some of the system users do not know how and under what circumstances to add an alert to the system. We found that there is no consistent approach across the HB when alerts should be used for notification purposes and who should add them to patients' records. See matter arising three in Appendix A. <u>Mental Health Wards</u> Welsh Community Care Information System (WCCIS) is used for patients' data recording. The database does not have a dedicated place for dementia diagnosis or related notes. Similar to the CWS system, this system has an alert functionality. However, this is not widely used for dementia identification purposes. From our nine selected patients, none of the patients (0%) had dementia alert. Also, finding the dementia diagnosis can be time consuming, as it requires going through past entries. See matter arising three in Appendix A.
Paper files !	<u>General Wards</u> Our findings related to this section were quite similar to the issues we had highlighted in our previous 2022/23 Records Management audit (rated 'limited' assurance) e.g. that certain documents were not filed, or blank forms were stored within in the patient's folders (e.g. risk assessment documents, documents about dementia diagnosis, OAPL referrals and updates or a formal care plan etc.) See matter arising three in Appendix A

	Mental Health Wards There were practical difficulties with the paper folder in use on wards, for the storage of patient records. In particular, the physical insertion of the patient records. See matter arising three in Appendix A. We also found that some of the files did not include any risk assessment documents, documents about dementia diagnosis, OAPL referrals and updates or a formal care plan etc…) See matter arising three in Appendix A
Dementia symbols 	General Wards We found that all wards utilised the "daisy symbol" on their "Patient Status at a Glance" (P.S.A.G) board to identify patients within dementia mark dementia patients. Mental Health Wards The daisy symbol was used to identify patients with dementia patients.

Conclusion:

2.11 We identified recommendations relating to record keeping, in particular, the recording of patients with dementia. Therefore, we have provided **limited assurance** over this audit objective.

Audit objective 3: Monitoring – the patients are subject to regular assessments, and care services provided to them are appropriate for their needs

- *Ward Services*

2.12 Patients with more complex needs usually have an enhanced care package. However, we found that while care was in place (e.g. regular supervision) at all locations, monitoring sheets were not always signed or dated in line with the requirements. This has been included within matter arising three in Appendix A.

2.13 We also found that most of the wards did not have easy access to Welsh speakers. However, none of the patients within dementia spoke Welsh only. See matter arising four in Appendix A.

2.14 Some of the wards ensure patients with dementia are grouped together e.g. place them into the same activity room for the day or keep them in the same bay. Whilst this enables focussed care, there is a risk of a patient with dementia creating a noisy environment that may negatively impact other patients.

2.15 Furthermore, we identified several patients that had been transferred to a ward outside of their locality, thus increasing difficulty for family members and friends to visit. This has been included within matter arising four in Appendix A.

2.16 In addition, we also found patients who were moved around and admitted to different wards during their hospital stay. See matter arising four in Appendix A.

- *Older Adult Psychiatric Liaison (OAPL) Services*

2.17 The OAPL teams are specialist multidisciplinary mental health teams working in ABUHB hospitals to support patients with mental health problems/concerns during their assessment, diagnosis, and treatment. This programme is funded by the Welsh Government and involves mental health liaison predominantly for older people.

2.18 The OAPL teams operate from two main sites (RGH and NHH) and also cover the surrounding hospitals, where required.

2.19 The ward is required to issue a referral letter in order to request an OAPL visit. Once the referral is made, then the OAPL team would regularly visit the patient at the ward. While we were able to confirm the existence of these visits from the notes (usually marked with a sticker entry), we note that some of the wards were quicker to request the services, while others delayed them or not utilised them at all. We also found that in some cases the referral letter was not kept on file or has not been uploaded to the electronic system. See matter arising four in Appendix A.

Conclusion:

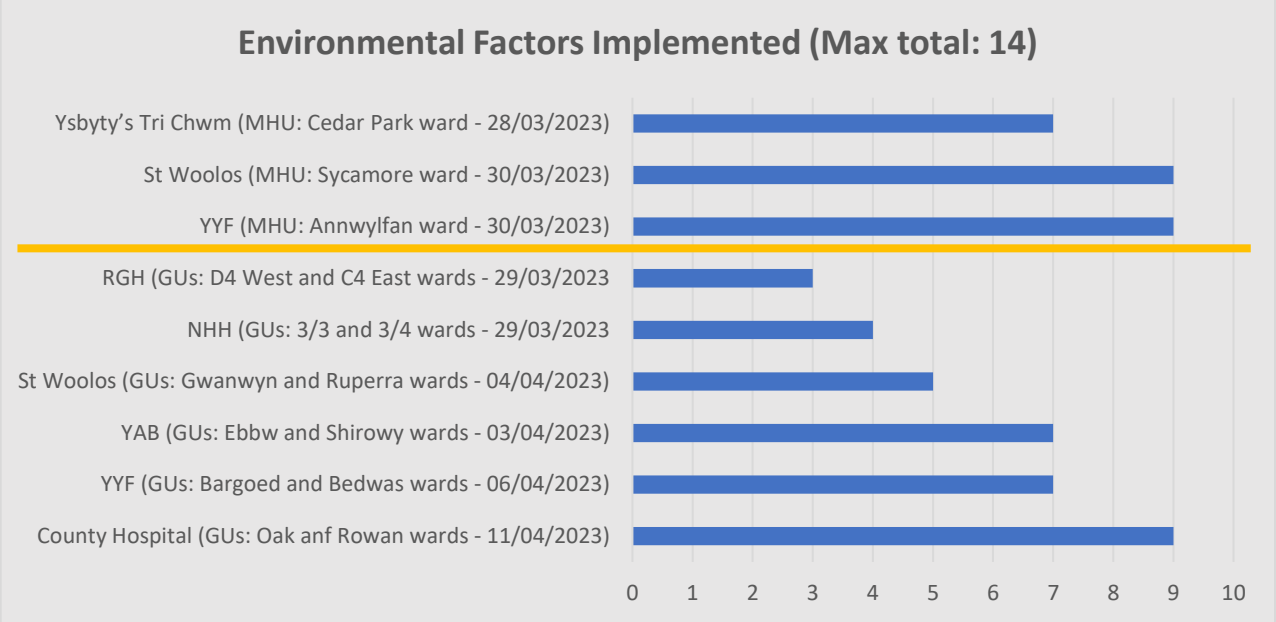
2.20 We identified three low priority recommendations relating to requesting OAPL services. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Care environment – the ward environment is suitable for patients, including appropriate infection control measures

2.21 As part of this objective, we looked at key environmental factors which would have a direct impact on patients with dementia, during their hospital stay.

2.22 We note that there is an Environment Assessment Tool created by the King's Fund, to identify whether a ward is dementia friendly. We considered a sample of the requirements set out within the assessment tool and this is reported within Appendix C.

2.23 In total, we reviewed 13 different environmental factors / criteria, and based on our findings, we rated the different hospitals. For each factor assessed, we collated the total number of factors in place on each ward visited. A summary of our findings is presented below.



2.24 For each of the environmental factors assessed we have provided an overall conclusion in the table below.

Factors	Status	Comments
1. CCTV camera	!	Except for two locations, we found that CCTV cameras were not installed for monitoring purposes.
2. Door security	!	All wards had electronic doors to ensure secured access to them.
3. Flooring	!	We found that in two cases the flooring on the ward was patterned and had different colours. One of the wards had bright white dots on the floor which remained from during the pandemic, as part of social distancing measures.
4. Hazards	!	We saw examples of manual handling equipment stored (steadies, hoists) within corridors, due to limited storage places, potentially creating hazards to mobile patients and staff.
5. Activity room	!	We found that some of the activity rooms were very small and had no real features or was used for other purposes. One room was cut off from the corridor and did not have a door for privacy. We also found that in one case the activity room was used to accommodate a patient, who was on a trolley due to limited bed / room availabilities on the ward. At the same hospital, another ward confirmed that the same practice was in operation, due to limited bed availability.
6. Personal clothing	!	Some of the wards allow and welcome families to bring in clothes for their relatives. However, none of the wards have any laundry facilities to wash personal clothing. As such there is a reliance on the families to launder clothes. Patients with no families are usually offered hospital gowns or donated / left over clothes.
7. Noise levels	!	We found that patients were mixed at some wards (e.g. patients with and without dementia) and were cared for next to each other. We also identified a risk of high noise levels, which may disturb patients with dementia, especially where there are staff shortages and space limitations.
8. Garden access	!	We found that except for three wards, the rest did not have access to a secured garden. However, whilst the hospital sites have a public garden there was a reluctance with staff interviewed to take patients within dementia outside.

9. TV		Some wards had multiple televisions, whilst others had just one within the day room.
10. Motion sensor items (wall mounted, clippers and sensory bed sheets)		There is a mixed approach amongst the wards. Many of the wards do not use any sensory items. We found that one ward had wall mounted motion sensors above each bed which they were able to switch on and off for each bed. Furthermore, we found that some of the wards were using sensory sheets on beds and chairs. However, we were told that this cannot be used for all types of patients.
11. Wall / door style and wall mounted features, pictures, interactive sensory boards)		We found different approaches to wall features and other decorations, ranging from clocks with batteries that did not work, to the decoration of single rooms. Overall, there was a varied approach across different sites and wards.
12. Therapy dogs		We were told that three wards used to have a therapy dog to visit patients every week. However, at one of these wards the service was stopped following the pandemic. We also note that these three wards often allow family dogs to visit the ward on weekends.
13. Toilet signs		We found two wards where the toilet frames were purposely painted different colours to draw patients' attention to them. However, at most of the wards the toilets were not very well sign posted.

2.25 We have raised a recommendation to help support the points raised above within matter arising five.

Conclusion:

2.26 Overall, we note that some of the challenges that are faced by the wards are originating from the physical layout of the hospital building and limitations to access funding streams for improvements. We also found that staffing levels impacted the level of dementia services that the ward were capable of offering. However, we found that staff were dedicated, and often creative in providing a high standard of services at all locations to patients within dementia. We identified one low priority recommendation relating to the sharing of good practice. Therefore, we have provided **reasonable assurance** over this audit objective. However, this objective does closely link to matter arising one, within audit objective one.

Appendix A: Management Action Plan

Matter arising 1: Standards Implementation (operation)	Impact
There is no deadline date for the implementation of the Standards, including the Hospital Charter, set by the Welsh Government. Consequently, whilst action is underway by the Health Board, there are no timeframes set by the Health Board to implement the requirements. We reviewed 53 principles from the 102 SPACE-VG principles listed within the "Dementia Friendly Hospital Charter" (51.96%) and found 24 principles still underway. The Health Board is currently working to implement the remaining requirements. However, there is no formal timeframe issued by the Welsh Government and there will be difficulties to implement some of the requirements, due to physical environment constraints.	Potential risk of: • The delivery of "Dementia Friendly Hospital Charter" is implemented at a slow pace.

Categories	Number of principles within the category	Number of principles assessed
S – Staffing	14	11
P – Partnership	10	7
A – Assessment	16	3
C – Care	17	12
E – Environment	14	7
V - Volunteering	6	0
G - Governance	25	7
TOTAL	**102**	**53**

We have provided further detail within Appendix B against each of the principles reviewed.

Recommendations	Priority
1.1 Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	Medium (Operation)

Management response	Target Date	Responsible Officer
1.1 The Standards have been developed and published by Improvement Cymru. There are no National Deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back to the Regional Partnership Board. The newly appointed Dementia Programme Manager will oversee all workstreams and, alongside reporting progress, we will report by exception any issues relating to implementing the Standards. Should Improvement Cymru produce deadlines, we shall revisit this recommendation. Additionally, once KPIs have been developed over the next 12 months, we will consider how we can best set formal deadlines for reporting. ***Auditors' comment on management response*** We agree with the current approach in the absence of mandatory deadlines. Therefore, whilst formal deadlines may not be the most suitable approach, we believe that the Health Board should continue to focus on the key principles of the Standards and the implementation of these. However, as this will be closely integrated with performance metrics and current monitoring arrangements, we recommend that exceptions are regularly escalated / reported following the commencement of workstream monitoring by the Dementia Programme Manager.	End of July 2024	Head of Nursing Person Centred Care

Matter arising 2: Enhanced Observation Framework (operation)	Impact
We found no or little evidence that audits / spot checks had been carried out for the new Enhanced Observation Framework (the 'Framework') at the wards. Furthermore, we note that the "this is me" document was not widely completed across the Health Board, despite the Framework referencing it. The Framework states that the "this is me" document must be completed in conjunction with the Management Plan and Toolkit document, if the patient is cognitively impaired. We only found such documents completed in the case of four wards. We also found that some of these documents were blank or only partially filled in. In addition, assessments over the suitability of ward environments for patients with dementia, as set out within the King's Fund Assessment Tool, have not been completed.	Potential risk of: • Non-compliance with internal framework • Loss of valuable information about patients • Wards do not provide the optimal environment for patients with dementia

Recommendations	Priority
2.1 Spot checks / audits should be regularly carried out to review compliance with the Enhanced Observation Framework.	Medium (Operation)
2.2 There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia.	Medium (Design)
2.3 Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings.	Low (Design)

Management response	Target Date	Responsible Officer
2.1 The Enhanced Care Framework, although not specific to Dementia aims to guide staff through what to consider prior to securing additional support. The enhanced observation policies are different on all Mental Health and Learning Disabilities Units. We shall use this recommendation to review the enhanced care framework and associated policies. Workstream 4 leads will be asked to review the Enhanced Care	October 2023	Lead Nurse Dementia

	Policy and determine how this can better align to VIPS monitoring for people with dementia.		
2.2	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this.	June 2023	Lead Nurse Dementia
2.3	*This is me* is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	June 2023	Head of Nursing Person Centred Care and Lead Nurse Dementia with Associated Standards Workstream Leads

Matter arising 3: Patients' records (design)	Impact
Electronic records We found that there was no dedicated section to record dementia diagnosis in CWS and WCCIS (e.g. no special field or subfolder option). As such, it can be time consuming to review past records to determine the patient's medical circumstances. There were also inconsistent approaches to name and up-load documents into the electronic systems. We also note that while both electronic systems have the functionality to add "alerts" to patients, this was not typically used for patients with dementia. Within our sample, we found that dementia alerts were used only in the case of three patients at the general wards, and not at all when we examined a sample of patients on mental health units. **Paper records** A new paper folder style was introduced to the MHUs last year. While the new folders were used at all of the locations that we have visited, staff had negative comments regarding the paper folders. This new style is a three-sided folder which does not have a binder ring structure in the middle. As patient's records are usually uploaded at the point of discharge or later, we found an accumulation of documents in the file, which are often mixed up or falling out of the folder. We also found that the monitoring sheets were not always signed and dated.	Potential risk of: • Inaccurate recording • Limitation to retrieve valuable data

Recommendations		Priority
3.1	Consideration should be given to make the electronic recording fit for dementia services. For example, add or change menu structure or introduce a dedicated field to highlight dementia diagnose.	Medium (Design)
3.2	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system.	Medium (Design)
3.3	Training should be provided to ensure a consistent approach for the electronic and paper records completion.	Low (Design)
3.4	Consideration should be given to revisit the appropriateness of the paper folder file style for the MHUs, to improve efficiency of access to patient files.	Low (Operation)

Management response		Target Date	Responsible Officer
3.1	Workstream 5b leads, along with Performance Team support, will review the electronic information and ensure the recording is appropriate for dementia services going forward.	August 2023	Programme Manager
3.2	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff.	July 2023	Informatics Programme Manager - WCCIS
3.3	We will review the training components and update where required, to ensure a consistent approach is adopted.	July 2023	Lead Nurse for OAMH and Informatics Programme Manager - WCCIS
3.4	The OAMH Directorate will review the paper folder files and implement any improvements required.	July 2023	Lead Nurse for OAMH

Matter arising 4: Hospitalisation (design)	Impact
During our ward visits, we came across a handful of patients who had been moved out from their catchment areas, and this had placed a pressure on the patient's support network to maintain visits. We are aware of one family that has formally requested to move their relative back to their locality, however, we were informed that this patient was not medically fit for transportation at the time of our visit. In addition, we also found patients who were admitted to different wards during their hospital stay. Furthermore, we note that many of the wards that we visited did not have Welsh speaking staff on board. However, none of our selected patients were Welsh speaking only.	Potential risk of: • Unnecessary stress on the patients and their families and network

Recommendations	Priority
4.1 Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Low (Design)
4.2 Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Low (Design)
4.3 There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	Low (Operation)

Management response	Target Date	Responsible Officer
4.1 Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	August 2023	Programme Manager
4.2 Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	September 2023	Programme Manager linking in with Patient Flow Leads
4.3 The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh	September 2023	Lead Nurse Dementia

Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.

Matter arising 5: Local initiatives (design)	Impact
We note that some of the wards with their dementia service approach were more advanced than others, and many of them implemented local initiatives. However, success stories / good practice relating to these initiatives were not routinely shared across the Health Board.	Potential risk of: • Lack of lessons learned • Good practice not shared amongst ward staff

Recommendations	Priority
5.1 Local initiatives with success stories should be channelled and discussed at existing forums.	Low (Design)

Management response	Target Date	Responsible Officer
5.1 Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	September 2023	Head of Nursing Person Centred Care and Lead Nurse Dementia

Appendix B: Sample of principles reviewed from the Hospital Charter

The Dementia Friendly Hospital Charter for Wales (the 'Charter') was adopted by the Health Board. The Charter identifies seven Principles (SPACE-VG). As part of our review we reviewed some of the principles when we undertook our site visits. As there is no date set by the Welsh Government for implementation, we have listed the areas tested where work is still underway to implement the principles, together with the current status. This is reported within matter arising one in Appendix A.

(S) – Staffing – Charter Principles	Current Status
• Staff are valued, are in the habit of sharing good practice and the good work they deliver is celebrated.	Successful initiatives are not always shared across the Health Board.
• Specialist dementia care staff are available, routinely offering support and advice where required within inpatient and community settings	There were wards with staff shortage.
• All aspects of care and care planning involve the person and carers, family members, supporters, and care home staff where appropriate.	
• Dementia care learning and development is mandatory for all staff and volunteers working in clinical areas with people living with dementia. The training should be at the appropriate level which is described in the Good Work Framework. This should involve how to assess needs and plan care. Once the care has taken place, we should see whether this has made a difference to the person.	There is a course available on ESR, but face to face dementia training is only offered to a limited number of staff.
• Observations of the person's experience is examined using tools such as Dementia Care Mapping. This information is then used to develop ways of moving forward and supporting learning.	We found no evidence of Dementia Care Mapping.
• Staff enable people to participate in activities in addition to care. This may be as simple as engaging in a conversation or providing stimulation in the form of things that they enjoy such as leisure activities	All locations had an activity room. However, the size and features of this room varied across the Health Board, due to physical constraints. We also noted that at some locations this room was used for other purposes (e.g. boarding patients / storing things / non-dementia services). We also note that due to staff shortages at some locations, the activity room was not always utilised, and as such, no meaningful activities were organised or carried out for dementia patients.
• Staff are aware of the importance of ensuring Welsh speakers are offered services in Welsh and other languages. Staff recruitment and training will support this.	Staff are generally aware of the importance of Welsh Services, however, many of the wards do not have Welsh speakers readily available, if required.

(P) – Partnership – charter principles	Findings
• The organisation uses the 'Triangle of Care' principles between the person with dementia, health professionals and their family/carers. The implementation of John's Campaign[2] or other carer focussed projects give the family, carers, and supporters a voice and allows their needs to be considered.	The Health Board has adopted John's Campaign; however, the adoption level was inconsistent across the organisation. Visiting hours of the wards were usually fixed, however, some wards are better suited to accommodate overnight stays for carers. We also note that many of the wards were happy to utilise the extra pair of hands to look after their patients – especially at mealtimes.
• Seamless transition between care settings and home is seen as vital. Discharge planning starts on the day of arrival into hospital. Either the person with dementia or someone who can represent their needs should be involved in co-ordinating their care.	We were told that there are delays discharging patients if the patients are cared for outside of their catchment area. We were also told that this often has an impact on patients' mobility as patients are required to stay in bed for a longer period of time, which could ultimately result in muscle wastage and lost independence.
• People's language preference and cultural needs should be recorded and acted upon to form part of their plan of care. This should always be communicated between the staff involved	We found that language preference and cultural needs are not necessarily captured in full within the electronic records. Also, many of the wards had limited options to fulfil / accommodate such individual needs.
• The person has a document that tells you useful information about them and their life such as a 'This Is Me' document. This document is always kept with them and updated by care partners and health professionals. This ensures that everyone can engage on a personal level and are aware of the needs and preferences of the person.	The "this is me" document was not widely used across the Health Board, despite the fact that the new Person-Centred Enhanced Observation Framework, which was launched in 2022 refers to it. The Framework states that the "this is me" document must be completed in conjunction with the Management Plan and Toolkit document if the patient is cognitively impaired. We only found such documents in the case of four wards. We also found that some of these documents were blank or only partially filled in.

[2] John's Campaign was launched in November 2014 by London based carer Nicci Gerrard after the death of her father, Dr John Gerrard, who had been living with dementia and declined rapidly after a stay in hospital where visiting times for carers were restricted. The John's Campaign is aimed to help to make carers of people with dementia welcome on hospital wards and reflects a positive attitude towards the importance of carers and sensitivity of their needs. Whilst there are no specific 'rules' associated with this Campaign, there is an expectation that when a person with dementia is admitted to hospital the person closest to them has a right to stay and to be exempt from any restrictions on visiting.

(A) – Assessment – Charter Principles	Findings
• People are not 'labelled', and staff understand and explore the person's regular routines, preferences, and responses. Changes in a person's behaviour should not be ignored.	We found three patients who were incorrectly labelled with a dementia diagnosis, due to the use of a previously completed template.
• For people that speak Welsh, care is delivered by Welsh speaking practitioners avoiding the use of translation services and where there is a language barrier, interpreters will be used.	We found that none of the selected dementia patients spoke Welsh only. However, we note that if they would, some of the wards would struggle to provide Welsh speaking carers.

(C) – Care – Charter Principles	Findings
• The views, opinions and preferences of the person with dementia, their carer, family or advocate are actively sought out. These views should help form their plan and delivery of care.	We found that some of the patients were placed outside of their catchment area, causing difficulties to their family and friends' network to be involved in their care (e.g. visit them at the hospital).
• The use of documents such as 'This is Me' are used to make connections with people living with dementia. They should be read, reviewed and updated regularly	At four wards we found that the "this is me" document was on file. However, some of them were blank or only partially filled in. We found no evidence that this document was regularly updated and reviewed.
• Care, information and support will be provided in the language of preference if that is the person's need or requirement.	Many of the wards did not have any Welsh speaking staff, therefore they had no ability to accommodate Welsh patients' language preferences.
• Staff ensure that people with dementia can maintain physical contact and relationships with their loved ones and significant people in their lives.	Some of the patients were placed outside of their catchment areas, causing difficulties to their families and friends' network to be involved in their care.
• Care can include technology. There should be access to free Wi-Fi and technological devices	Many of the wards had no access to additional technology facilities. We also found that some of the wards had only one TV in the activity room, but due to staff shortages patients had no access to it.
• People with dementia are supported to take positive risks that will continue to promote their independence and happiness, such as engaging in leisure activities if it is safe to do so	We found that meaningful activities for dementia patients were limited or not offered at some wards due to staff shortages and space issues.

E – Environment – Charter Principles	Findings
• Where possible, there is a supported dementia friendly outside space or garden that people with dementia, carers and family can access and enjoy. • The area offers quiet spaces designed for people to ensure that noise and distractions are minimised. • The environment helps people to see, hear and communicate better and promote independence	Only three wards had access to a secure garden. We found several wards where dementia patients were mixed together with non-dementia patients in 4 and 6 bed bays. Furthermore, we visited one ward which had a bay with six dementia patients who were bed bound, and two of the patients were very "noisy" and aggravated the other patients in the room. We found that this ward has single cubicles too, however, did not have enough staff to separate and care for the patients separately.

G – Governance – Charter Principles	Findings
Communication Principles • Services provide an active offer in Welsh where it is the person's primary language. Staff are supported to deliver care in Welsh. Services and care will be provided in Welsh and other languages where needed. Staff are encouraged to improve their Welsh language skills. • Services provide translation in the person's primary language to support communication and care. This would also include the use of British Sign Language (BSL) interpreters.	Staff are allowed to wear a symbol on their clothes e.g. "currently learning Welsh" or "Welsh speaker". However, we have not seen any of these symbols in practice at the wards. We also note that many of the wards did not have access to Welsh speakers that could assist. We saw one example of this with other language requirements too.

Appendix C: Sample of questions reviewed from the King's Fund Assessment

In 2014, the King's Fund [3] developed a suite of environmental assessment tools for use across health care settings as part of the Enhancing the Healing Environment (EHE) programme, which was updated by the Association for Dementia Studies, University Worcester in 2020. This latest assessment tool contains seven sections with a set of questions for each section. As part of our review, we looked at and assessed the position for a sample of questions from this Assessment Tool. See summary of our findings below. As with the Hospital Charter, we have included the content of this appendix within matter arising one in Appendix A.

1. The environment promotes meaningful interaction between patients, their families and staff	Findings
• Does the approach to the ward look and feel welcoming and is there an obvious reception desk with the ward name clearly displayed?	We found that the wards were clearly labelled and direction to them was clear. However, some of them did not have any formal reception areas.
• Are there social areas e.g. day rooms, that offer a choice of seating including chairs with arms?	We found that all wards had a "day room" (some also had a dining room). However, some of the wards used this room for other purposes. We were also told that due to staff shortages some of day rooms were not utilised for dementia services.
• Are there opportunities for patients to engage in social interaction away from the bedside e.g. at mealtimes or during activities?	We found that meaningful activities were not offered to dementia patients at some of the ward locations but were at others.
• Are activities encouraged for patients by their bedside in addition to passively watching TV?	
• Do family carers have extended visiting opportunities and is there provision for them to stay overnight?	Different protocols were in place at different wards.

2. The environment promotes well-being	Findings
• Are links to and views of nature maximised e.g. by having low windows and using natural materials and colours?	Many of the wards had limited views of nature due to the layout of the ward within the hospital setting.
• Is there independent access to a pleasant, sociable, safe outside space e.g. garden, courtyard, or terrace, with sheltered seating areas?	We found that only three of the wards had access to a secure garden.

[3] The King's Fund is an independent charitable organisation working to improve health and care in England.

3. The environment encourages eating and drinking	Findings
• Is a choice of finger foods available at mealtimes?	We found that in the case of two wards, meals had to be ordered 24 / 48 hours in advance. We were told that this often causes some issues with patients with dementia.
• Is there a space away from the bedside where patients can eat together?	Only a handful of the wards had a dining room where patients could eat together, or their activity room was suitable to be transformed into a dining room.

4. The environment promotes mobility	Findings
• Is there space for patients to walk around independently?	We found one ward where manual handling equipment (e.g. hoists and steadies) were stored in the corridor creating potential hazards both for the patients and staff.
• Are the flooring and thresholds of a consistent colour, matt, non-reflective, non-patterned and not slippery?	We found two wards where the flooring on the corridor was patterned, as such could be interpreted as "uneven" surface by a dementia patient. We note that one of the wards had bright white dots painted onto the floor from Covid time, which had not yet been cleared.
• Are there small seating areas for people to rest along corridors and/or by the reception desk or nurses' station?	We did not find any sitting areas within the corridors. However, we note that one of the wards' dayroom was created from the corner of the corridor, as such, it did not have any door on it.
• Are points of interest e.g. artworks or photographs of local scenes, on the walls hung at a height where they can be easily seen?	Most of the wards only had white walls. However, some wards had art works or wall mounted sensory features. We found one ward, where even the windows were decorated. Overall, we note that the wards took a different approach to make their wards more welcoming. e.g. put famous music players on the wall.

5. The environment promotes continence and personal hygiene	Findings
• Do the signs to the toilets include clearly identifiable images and text, and can they be seen clearly from all patient areas?	Most of the toilets had image signs and text on the doors. However, these were mainly visible at front of the door only.
• Are all doors to toilets painted in a single distinctive colour and do they have the same clear signage?	We found two wards where distinctive colours were used on the door frames of the toilets.

6. The environment promotes orientation	Findings
• Are signs for staff e.g. sluice or treatment room, out of general eyesight?	We found that some of the treatment and medication room doors were left wide open.
• Have artworks/objects and accent colours been used to enhance orientation and wayfinding?	Some of the wards had blank walls, while others had art works or wall mounted sensory features. One of the wards, even had a "bus stop" sign. Overall, we note that the wards took a different approach to make their wards more welcoming.
• Are single rooms/bed spaces personalised e.g. through the use of numbers, accent colours, artworks, or personal photographs?	We found that some of the wards were more flexible than others to personalise single cubicles, while other wards chose to cut back on any personalisation due to infection risk.
• Have strong patterns or images been avoided e.g. in wall coverings, curtains, furnishings, and screens?	We saw that some of the bay settings included curtains around the patient beds, however, this was not the case everywhere. We note that one of curtains was on the floor due to broken fittings for a number of days, creating a more hazardous environment for patients with dementia.
• Is there a large, accurate and silent clock (approximately 18”/45cm diameter) clearly visible in all patient areas?	We saw a lot of clocks throughout our ward visits, however, most of them did not work (e.g. had a flat battery), as such, they did not show the correct time.
• Is the correct day and date displayed and clearly visible in all patient areas?	We note that some of the clocks were combined with a date display - however, similar to the clocks, some of them did not work. We note that most of the wards had no formal date display for their patients.

7. The environment promotes calm, safety and security	Findings
• Are notices kept to a minimum to avoid distraction and confusion?	We found one ward, where we witnessed that noises from two patients with dementia were disturbing other patients in the same bay.
• Are spaces and corridors clutter free?	We found one ward where manual handling equipment (e.g. hoists and steadies) were stored in the corridor creating potential hazards both for the patients and staff.

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence presents of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Contract Management
Final Internal Audit Report

July 2023

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Contents

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Executive sign-off:	Leanne Watkins, Chief Operating Officer Rob Holcombe, Director of Finance, Procurement and Value
Distribution:	Greg Bowen, Assistant Finance Director, Hospital and Corporate Heulwen Griffiths, Head of Business Systems and Governance Alex Curley, Head of Sourcing (Pharmacy)
Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

This internal audit has been undertaken to provide a review of the effectiveness of the management of operational contracts entered into by Aneurin Bevan University Health Board (the 'Health Board').

Overview

Contract management processes are not defined in a policy or guidance documentation, and this has led to contracts being managed on an individual approach. However, the actions completed by operational managers within the sample tested were often in accordance with expected controls (e.g. contract meetings / performance monitoring).

There is a need to define how the Health Board wishes to manage its operational contracts, communicate the process and reinforce this through effective training of all those engaged in contract management procedures.

We also raised the following additional matters:

- the lack of contract risk registers to formally capture and manage potential contract risks; and
- the lack of a shared repository for all contract documentation.

To reach our conclusions above, we selected an expanded sample for testing.

Overall, whilst we are cognisant of the operational work undertaken by managers for each contract sampled, which contributed towards the overall assurance opinion, there is a level of inherent risk with this approach that requires addressing. Therefore, the absence of a documented approach should be resolved urgently.

All matters arising are detailed in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Integration of Procurement Policy and Contract Management Processes	Limited
2	Contract managers have the appropriate skills with access to relevant training and development	Limited
3	Contract management risks and performance are reported through the Health Board's governance structure	Reasonable
4	Contract specific objectives are evidenced re contract ownership, relevance and monitoring of service levels / deliverables, and reporting and tracking of performance	Reasonable

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Integration of Procurement Policy and Contract Management Processes	1,2,3	Design	High
1	Training Programme	1,2	Design	Medium
2	Contract Documentation	4	Design	Medium

1. Introduction

1.1 This internal audit was a review of the effectiveness of the management of operational contracts entered into by Aneurin Bevan University Health Board (the 'Health Board') and to provide the Health Board with assurance that operational procedures are compliant with Health Board corporate policies. This audit was not originally included within the Audit Plan for 2022-23, but rather, replaced the Urgent Care System review scheduled (due to overlapping audit work in that area).

1.2 In reviewing the effectiveness of the management of the operational phase of contracts, reference has been made to the Crown Commercial Service – Contract Management Framework and associated Good Practice Guides.

1.3 Objectives of the area covered under the review were:

- policy and procedural information is appropriate and available to relevant staff;
- contract managers have the appropriate skills with access to relevant training and development;
- contract management risks and performance are reported through the Health Board's governance structure; and,
- contract specific objectives:
  - contract ownership is clear, with the budget holder, senior responsible owner (SRO) and contract manager clearly defined;
  - service levels/ deliverables are specified in the contract and are linked to service needs and monitored by the contract manager and/or end users; and
  - contract performance and risk is reported and managed within the Health Board's governance structure.

1.4 The risks considered in the review included:

- effective contract management arrangements are not in place;
- contract risk is not managed effectively resulting in increased financial cost and / or reputational damage;
- contract service level is not delivered by the supplier(s); and
- staff are unaware of responsibilities regarding contracts.

1.5 We reviewed in detail the contract management processes adopted for a sample of contracts selected from the spreadsheet record, maintained by the NWSSP Procurement Team, embedded in the Health Board. The sample consisted of contracts that were all active at the time of the audit and reflected the engagement of a range of operational divisions. Whilst we extended the sample of contracts selected to capture a greater variety of contracts during the audit, we reached similar conclusions to those drawn on the original sample of contracts reviewed.

2. Detailed Findings

The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	2	-	3
Operating Effectiveness	-	-	-	-
Total	1	2	-	3

Objective 1: Policy and procedural information is appropriate and available to relevant staff

2.1 The Health Board has a detailed Procurement Policy and Financial Control Procedure document. However, there is little integration with, or reference to, contract management processes, or any associated linkages to relevant sites, detailed in the document. In addition, when reviewing those links that were embedded in the Procurement Policy it was noted that not all were directing staff to the relevant sites. We have raised these findings in matter arising one in Appendix A.

2.2 There is no specific Health Board policy or guidance approved and issued on the subject of the contract management process requirements. This has resulted in individual contracts being managed in differing ways, with no consistency of approach. We have raised this finding in matter arising one in Appendix A.

Conclusion:

2.3 We have raised one matter arising under this objective. There is a need to develop and integrate contract management procedural information, once developed, with the existing Procurement Policy and Financial Control Procedures. Therefore, we have provided **limited assurance** over this area.

Objective 2: Contract managers have the appropriate skills with access to relevant training and development

2.4 From the sample of contracts tested during the audit, we found that whilst those individuals delivering contract manager procedures had relevant qualifications and experience, none of the individuals responsible operationally for the contracts sampled had been provided with any specific and / or consistent contract management training. This was more of a concern for operational staff engaged in contract management procedures as they were less likely to have any relevant qualification or experience of contract management. We have raised this finding in matter arising one in Appendix A.

2.5 The lack of training and support is exacerbated by the lack of policy and guidance issued on the contract management process and has resulted in individual contracts being managed individually with no overarching structure / framework that can be applied to each contract. We have raised this finding in matter arising one in Appendix A.

Conclusion:

2.6 We have raised one matter arising under this objective, commenting on the lack of policy and guidance, combined with a lack of training of those engaged in the contract management process. This results in a variable approach that may not deliver consistent efficiency and effectiveness and / or may result in duplication of effort. However, whilst there is a lack of formal training and documentation, we found that the actual management of the contracts, including resolving issues that arise, escalation and ongoing monitoring, was taking place. Overall, we have provided **limited assurance** over this area.

Objective 3: Contract management risks and performance are reported through the Health Board's governance structure

2.7 From the sample of contracts tested during the audit, it was noted that performance was being monitored and reported both internally and externally via contract review meetings with the provider. Where performance was below that expected per the contracts reviewed, there were escalation processes within the contracts sampled to drive corrective behaviour and to invoke financial penalties, as appropriate.

2.8 However, whilst risks were being managed, the use of contract specific risk registers was limited in the sample reviewed. This may expose the Health Board to having to manage events once they have occurred, rather than being able to be proactive and identify risks, assess them and initiate any remediating actions. We have raised this finding in matter arising one in Appendix A.

Conclusion:

2.9 We have raised one matter arising under this objective, the requirement for all contracts to maintain a formal contract risk register and to feed risks into the Health Board's risk management framework. We have provided **reasonable assurance** over this area, subject to the contract managers engaged on the sample contracts having relevant contract management qualifications and experience.

Objective 4: Contract specific objectives are evidenced re contract ownership, relevance and monitoring of service levels / deliverables, and reporting and tracking of performance and risk

2.10 As noted in objective two above, there is a lack of policy and guidance with regard to the contract management process and this has resulted in contracts being managed independently, see matter arising one.

2.11 From the sample of contracts tested, it has been noted in objective three above that the monitoring of performance was undertaken and that this was being reported internally and externally, but that formal contract risk management practices were not documented. This was included within matter arising one.

2.12 The Health Board does not have a readily available listing of all active operational contracts and all related, signed documentation, held on a single shared platform.

2.13 From the contracts sampled, we found that the list of active contracts provided by the NWSSP Procurement Team was not consistent with the detailed information held by the operational contract managers. Furthermore, the information held was not available on a shared platform, linking signed contracts and other related documentation. We have raised this finding in matter arising two in Appendix A.

Conclusion:

2.14 We have raised one matter under this objective, the requirement for an effective shared repository of all contract documentation currently held operationally and / or with the NWSSP Procurement Team embedded within the Health Board. We have provided **reasonable assurance** over this area.

Appendix A: Management Action Plan

Matter arising 1: Contract Management Policy, Guidance, and Training (Design)	Impact
There is no Health Board Policy or guidance issued on the subject of the contract management process requirements at an operational level. This has resulted in individual contracts being managed in differing approaches. From a sample of contracts tested (five in total) it was noted that: • whilst those individuals providing contract manager processes had relevant qualifications and experience, the individuals had not been provided with any specific contract management training; • there is no overarching documentation of how each contract was to be managed. Consequently, there is a lack of clarity as to who is responsible for each contract, and the management therein; and • contract risk registers are not maintained. Whilst managers of the individual contracts sampled demonstrated an escalation process regarding matters of non-performance matters, there is a general lack of formal consideration given to what risks are inherent in each individual contract and how any such risks are being managed. Whilst the Health Board has a Procurement Policy and Financial Control Procedure document, it was noted that there is little integration with, or reference to, contract management processes.	Potential risk of: • Contracts are not managed in an effective and consistent manner. • Effective contract management arrangements are not evidenced.

Recommendations	Priority
1.1 We recommend that Health Board management ensure that a contract management policy and guidance is developed, approved, issued and communicated to all relevant staff. It should incorporate the following: ○ guidance over the operational management responsibilities associated with contracts, including the management / identification of contract risks, performance monitoring, escalation of matters arising etc.; ○ template documents to record details of how individual contracts are to be managed e.g. responsibility for oversight and delivery. This is particularly important where the responsibility lies across different functions within the Health Board; ○ the All Wales Procure to Pay e-Manual, issued by NWSSP Procurement includes a section on implementation and contract management processes and provides information that should be aligned to any position developed by the Health Board; and ○ the Procurement Policy and Financial Control Procedure is updated to incorporate any relevant references as a result of the above changes.	High
1.2 The introduction of contract management guidance and policy should be supported by the roll out of an appropriate training programme to all relevant staff, to assist with the embedding of the agreed approach.	Medium

Management Responses		Target Date	Responsible Officer
1.1	A contract Management Policy is in the process of being developed and due to be drafted by the end of July 2023 for consideration and approval by end August 2023. The policy will make reference to standard documentation in order to standardise the approach to contract management across the Health Board, and form a FCP.	August 2023	Assistant Finance Director Hospital and Corporate / Head of Sourcing (Pharmacy) FCP - Supported by: Head of Business Systems and Governance
1.2	Once the Policy is finalised a training programme will commence for all contract managers delivered by the Head of Procurement and Assistant Head of Procurement, supported by the Divisional Finance Business Partners.	December 2023 (twice yearly refresher training from January 2024)	Assistant Finance Director Hospital and Corporate / Head of Sourcing (Pharmacy)

Matter arising 2: Contract Documentation (Design)	Impact
The Health Board does not have a readily available listing of all active, operational contracts held on a shared platform. We found more detailed documentation held by operational contract managers, but not necessary on a shared platform.	Potential risk of: • Effective contract management arrangements are not evidenced as operating during the life of contracts with the risk of duplication or omission.

Recommendations	Priority
2.1 We recommend that Health Board management ensure that: a. A repository of all signed contractual documentation is established to include: all contract schedules, framework agreements, service level agreements, call off orders etc. b. The repository is placed on a shared platform such that it is accessible to all relevant staff / stakeholders.	Medium

Management Responses	Target Date	Responsible Officer
2.1 This is difficult as Procurement services who maintain the bulk of any contract documentation sits under NWSSP who have their own architecture within SharePoint which is not readily accessible to Health Board staff. It is proposed in the contract management policy that a contract management plan will be drafted between procurement and	December 2023	Head of Sourcing (Pharmacy)

the responsible division/contract manager with information to be issued back to procurement at regular intervals. This will ensure that all contract documentation is kept in one place and is accessible by contacting the procurement team.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Head of Internal Audit Opinion & Annual Report 2022/2023

juli 2023

Aneurin Bevan University Health Board

Contents

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1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Aneurin Bevan University Health Board (the 'Health Board') is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule. Changes required during the year have been approved by the Audit, Risk and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2022/23 year was initially presented to the Committee in April 2022.

There are, as in previous years, audits undertaken at NWSSP that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy in March 2023, and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2022/23. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS'.

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2022/23

Substantial Assurance	Reasonable Assurance
• Digital Benefits Realisation • Cyber Security • IAP - Grange University Hospital	• Risk Management • Financial Sustainability • Neighbourhood Care Networks • Mental Health Transformation • Dementia Services • Infection Prevention and Control • Integrated Wellbeing Networks • Job Evaluation Process • Monitoring Action Plans • Management of the Robotic Process Automation • IT Strategy • IAP – YYF Breast Care Services • IAP – Newport East • IAP – Satellite Radiotherapy Centre • IAP – Endoscopy Services • Children and Young People's Continuing Care (from 2021/22 plan) • Contract Management • Bank Office and Temporary Staff (Draft report)
Limited Assurance	**Advisory/Non-Opinion**
• Corporate Governance (Policy Management) • Clinical Audit • Use of Off-contract Agency • Discharge Planning • Records Management • Bevan Health and Wellbeing Centre	• Agile Delivery • Follow-up of High Priority Recommendations • Decarbonisation • Clinical Futures – Care Closer to Home • Putting Things Right (Draft report)
No Assurance	
• N/A	

Please note that our overall opinion has also taken into account information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2022/23 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit and Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - Yellow +	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23 and reported to the Audit, Risk and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially

complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the organisation.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively.

From the opinions issued during the year, three were allocated Substantial Assurance, eighteen were allocated Reasonable Assurance and six were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. We also issued five reports that were not rated.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken **four** reviews in this area.

We completed a review of **Risk Management** (reasonable assurance) where we assessed the risk management arrangements within a sample of divisions. Overall, we found good arrangements in place, but identified different approaches and the lack of formal reporting to risk management across the divisions sampled. However, we did confirm that risk related matters are escalated appropriately.

We completed a review of **Monitoring Action Plans** (reasonable assurance) where we examined the arrangements in place for tracking actions raised by external inspectorates. We focussed on actions raised by the HSE and HIW. We found the logging, tracking and monitoring of HIW actions to be robust. However, we raised recommendations to improve the tracking and escalation of HSE actions.

We completed a review of **Corporate Governance (Policy Management)** (limited assurance) was undertaken to review the process for the management of policies throughout the Health Board. We found that a large number of policies and other associated documentation was overdue for review. In addition, we raised recommendations over the process for reminding document owners of expired / expiring policies.

We completed the **Follow-up of High Priority Recommendations** review (not rated) where we assessed if high priority (and other significant) recommendations from within an appropriate period had been implemented, together with the Recommendation Tracker being updated accordingly. Overall, we found the process for updating the Recommendation Tracker and extending recommendation deadlines is clear. We made some minor suggestions to ensure the Tracker is fully accurate.

Strategic Planning, Performance Management & Reporting

We have undertaken **three** reviews in this area.

The **Mental Health Transformation** audit (reasonable assurance) was undertaken to provide a review of the controls in place for the projects that support the transformation of mental health services within the Health Board.

We found that projects delivering mental health transformation are managed well, with oversight provided, depending upon the nature of individual contracts. Whilst governance is consistently provided through the mental health transformation structures, it is also provided by other parties, both internal and external to the Health Board. There is a need for clarity on each project regarding the allocation of such roles and responsibilities to provide assurance that any gaps or duplication are

identified and addressed. We also raised a recommendation over the process for escalating significant matters arising.

As Clinical Futures – Care Closer to Home is a key strategy and objective that was tested extensively within the Mental Health Transformation, Neighbourhood Care Networks and Integrated Wellbeing Networks audits, the conclusions overlapped throughout these audits. Consequently, we provided a consolidated report, highlighting the key output from each of the corresponding audit reports. Whilst the consolidated **Clinical Futures – Care Closer to Home** report was not rated, the audits incorporated were all rated as reasonable assurance.

The **Integrated Wellbeing Networks** audit (reasonable assurance) sought to review the arrangements in place to improve and strengthen wellbeing within the community by utilising existing community assets. Overall, we found strong controls in place, with good governance of the Integrated Wellbeing Networks (IWNs) programme of work. However, we raised recommendations over defining the benefits to be realised and the communication and monitoring of plans.

Financial Governance and Management

We have undertaken **two** reviews in this area.

We completed an audit of **Financial Sustainability** (reasonable assurance) where we determined that the Health Board's budgetary control and savings plan processes are well designed. However, we found that the budget delegation letters were not fully accepted and signed within a timely manner. We also raised a recommendation regarding the non-achievement of saving plans and that actions should be established to achieve a financial recovery position.

We completed an audit of **Use of Off-contract Agency** (limited assurance) to assess whether off-contract agency processes are adhered to, and related expenditure is appropriately monitored. We noted control design weaknesses in the processes to minimise the use of off-contract agency and in our substantive testing of a sample of shifts filled by off-contract agency nurses found instances of practices not conducive to the achievement of this objective.

We also analysed the timeliness of actions set out within the process being completed e.g. the completion of a sample of rosters. Overall, we raised recommendations to:

- address the policy / procedures expiry;
- determine if all other resource actions had been explored prior to the approval of off-contract agency use; and
- improve compliance with the established process.

Quality & Safety

We have undertaken **three** reviews in this area.

The audit of **Infection Prevention and Control** (reasonable assurance) tested a sample of wards across multiple hospital sites, to determine the level of adherence to infection prevention and control procedures. We also assessed the governance arrangements in place. Overall, we found a positive compliance position with key policies sampled, although we did identify patterns of non-compliance within our sample tested.

The audit of **Children and Young People's Continuing Care** (reasonable assurance) considered the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Health Board's Children Community Nursing Service (CCNS).

We found that the CCNS is a well-managed service with robust governance, accountability and risk management mechanisms in place. However, the CCNS (and wider Division) faces some key challenges in the delivery of CYP CC including:

- significant vacancies (national shortage); and
- challenges to working with local authorities due to lack of clarity in national guidance.

The **Clinical Audit** review (limited assurance) was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance. Overall, we found significant improvement required in a number of key areas and in particular we raised recommendations over:

- a Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review;
- the lack of a local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits that should be completed may go unidentified, leading to additional clinical risks; and
- the tracking / monitoring of actions raised and the delivery of clinical audits.

Information Governance & Security

We have undertaken **five** reviews in this area.

The **Management of the Robotic Process Automation** audit (reasonable assurance) assessed whether an appropriate process is in place to securely develop the Robotic Process Automation (RPA) function. The RPA function was established as a pilot and has enacted good governance and controls. We raised a series of recommendations to ensure the benefits

are fully articulated, sufficient resource is in place and the change management process is embedded across the Health Board.

The **IT Strategy** audit (reasonable assurance) determined if the organisation has developed an appropriate target operating model to enable the delivery of the Digital Strategy.

We found that the Health Board has defined a digital operating model, and operating framework which sets out a re-aligned Informatics structure to enable support and digital transformation. A revised process for managing requests for Informatics input has been designed and this will better enable the translation of external / national projects into local projects with associated benefits. The implementation of the operating model has commenced, but has been delayed by the pandemic and resource issues within the Health Board. To support the process further, we raised recommendations to ensure processes are in place to align the Health Board's plans and embedding the ownership for digital across the organisation.

The **Records Management** audit (limited assurance) sought to provide assurance that the Health Board has an appropriate process for the management of records which ensures that it is compliant with legislation.

We found significant matters require management attention including:

- delays in the availability of records;
- inappropriate records storage and security at some sites;
- poor records management practices on the wards;
- limited ability to track certain records;
- inconsistent approach to escalate records management issues; and
- lack of uptake of records management training courses.

The **Digital Benefits Realisation** review (substantial assurance) assessed the Benefits Framework in place. We also assessed the coverage of the benefits management process. Overall, we found good arrangements in place, but raised a recommendation over the ensuring the benefits on national programmes are considered holistically on local programmes to enable prioritisation.

The **Cyber Security** audit (substantial assurance) provided assurance over the process in place for improving cyber security arrangements. We found a plan in place which incorporated actions from the Cyber Assessment Framework that had improved security.

Operational Service and Functional Management

We have undertaken **five** reviews in this area.

The **Neighbourhood Care Networks** audit (reasonable assurance) assessed the arrangements in place to improve access to primary care services. Whilst we found good governance arrangements in place over the neighbourhood care networks (NCNs) governance arrangements we recommended that measurable goals of the Accelerated Cluster Development programme are established and monitored.

The **Dementia Services** audit (reasonable assurance) reviewed the arrangements for acute patients with dementia. We assessed the implementation of the King's Fund Environmental Assessment Tool and the All Wales Dementia Care Pathway of Standards (the 'Standards'). Overall, we found the processes are well established, with the Hospital Charter and the Standards a key focus.

However, we raised recommendations over the implementation of the remaining Standards, the documentation of patient records and the embedding of the enhanced care framework.

The **Discharge Planning** audit (limited assurance) assessed the discharge planning process of the Health Board. We focussed on the management and delivery of planned discharges and undertook sample testing of patients admitted during April and May 2022.

We found that discharge planning practices were not supported by the out-of-date Discharge Policy, there was no compliance audit programme or reporting. Furthermore, based on the results of our sample testing, the evidential support of the discharge process was lacking. In addition, we raised comments on the simple and complex pathways approach, the use of checklists, and improvement in the reporting, analyses and actions to address avoidable re-admissions.

The **Contract Management** audit (reasonable assurance) assessed the operational management of a sample of Health Board specific contracts. Overall, within the sample tested, we found controls in operation were appropriate. However, there is no documented process to ensure consistency with the operational management of contracts. Therefore, we raised recommendations over the requirement to define this approach, together with the development of contract risk registers and a shared repository of contract information.

The **Putting Things Right** advisory review (draft report - not rated) assessed if there were alternative approaches or processes to strengthen the putting things right service within the Health Board. We provided recommendations to implement actions from lessons learnt, increase complaint analysis and to improve investigation timeframes.

Workforce Management

We have undertaken **three** reviews in this area.

The **Job Evaluation** audit (reasonable assurance) sought to provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook and is being applied effectively by the Health Board. We did not identify any significant matters, but did identify instances where evidence was not fully available.

The **Agile Delivery** advisory review (not rated) assessed the Health Board's progress in developing agile working practices and identification of good practice. We found that the number of staff working in an agile manner is in excess of the Welsh Government's target. To support this process there is an agile working framework and group to implement support and arrangements. However, we recommended a more formalised approach to implementing agile working, including a delivery plan and SMART delivery objectives.

The **Review of Bank Office and Temporary Staff** (draft report - reasonable assurance) assessed the operational arrangements in place within the Health Board to manage Bank and temporary staff. We also completed a follow-up review over the use of off-contract agency workers. Overall, we found good arrangements in place within the Bank Office Team, which were largely adhered to. We also confirmed that the controls implemented to reduce the use of off-contract agency staff have achieved their objectives, with reduced expenditure and utilisation. We confirmed that compliance with the processes has also improved considerably.

Capital & Estates Management

We have undertaken **seven** reviews in this area.

The **YYF Breast Care Services** audit (reasonable assurance) reviewed the arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit. The project was delayed by 12 months from its intended start date, primarily due to the change in market conditions and the withdrawal of the main sub-contractor's original cost submission. Accordingly, costs have been revised due to these changes with additional funding sought, and approved, by the Welsh Government. Budgeted costs were aligned with the revised funding, with no variance anticipated to date.

However, we raised recommendations to establish roles and responsibilities, improve the interaction of commercial meetings and to enhance the management and monitoring of key risks.

The **Newport East** review (reasonable assurance) was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives i.e. time, cost and quality.

The governance structure was supported by appropriately constituted Project and Commercial Teams, with clear engagement at the project from the SRO and Project Director. However, there is a need to review the effectiveness of the Programme Board in providing appropriate scrutiny and challenge.

However, despite the early stage of construction, contingency funds had already been reduced by 30%, primarily due to an increase to the target cost after FBC approval. Costed risks were reported to outweigh remaining contingency, placing the project under pressure before it enters the main construction phase.

The key matters identified include:

- the timely review and actioning of cost information;
- a need to review the constitution, capacity and function of the Programme Board to ensure it can effectively execute the role of Project Board (including adequate scrutiny and challenge) at major projects;
- the development of the Service risk register; and
- the authorisation of Project Control Forms and contract documents in line with the Scheme of Delegation.

The **Satellite Radiotherapy Centre** audit (reasonable assurance) was undertaken to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives.

Noting that the project had only recently commenced on site (January 2023), the project remained on programme and on budget. The audit found the following key issues:

- there was no evidence of the Project Board scrutinising/ approving the tender evaluation report.
- the timely and appropriate execution of contractual documentation.
- the need to formally record the users / stakeholders sign-off of the design and associated derogations.

The **Endoscopy Services** audit (reasonable assurance) was undertaken to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project.

We found that the project had slipped behind schedule (c. four weeks) with additional delays anticipated. However, a forecast underspend was anticipated, due to savings from the non-work cost element of funding.

We raised the following recommendations:

- the need to review and confirm the constitution, capacity and function of the project board and project to ensure that they can effectively execute their roles;
- the enhancement of project cost reporting to incorporate the full outturn costs; including equipment and the net VAT positions;
- the authorisation and execution of Service Level Agreements/contracts, in line with the Health Board's Scheme of Delegation;
- a review of value for money achieved from the successful main works contract award; noting only two tenders were submitted and the works cost was circa £900k above the pre-tender estimate; and
- availability of evidence to fully substantiate.

The **Decarbonisation** review (not rated) sought to determine if the implementation of the Health Board's Decarbonisation Action Plan (DAP) was on schedule. We found that throughout Wales there was significant progress still required to fund and implement the respective DAPs. Therefore, we provided recommendations to address the common themes identified. In particular the general conclusions across all DAPs were:

- the targets detailed within the plans showed low aspirations;
- there were concerns associated with their successful delivery, primarily due to resource availability (financial and physical); and
- there were a small number of issues associated with their compilation/format.

The **Grange University Hospital** audit (substantial assurance) assessed the evidence in place for the Stage Four (construction) defined costs claimed by the Supply Chain Partner. We found appropriate methodologies had been applied and that sufficient supporting evidence was provided.

The **Bevan Health and Wellbeing Centre** audit (Limited assurance) sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre. We found that:

- the project is being progressed significantly outside of its original target programme i.e. at the time of the audit fieldwork a 30 week in delay;
- there were associated current cost pressures at the project*;*
- there remain further significant risks not included within the forecast outturn cost projections;
- there were related issues with the on-going performance of the Supply Chain Partner.

We raised recommendations in relation to each of the above and also suggested improvement for the project governance arrangements.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on last year's programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in February and March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023;
- the results of the work completed by Audit Wales; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other member of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set out about below, with relevant comments and opinions attached, and relate to work at NHS Wales Shared Services Partnership.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline Scope
Accounts Payable	Reasonable	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place over the management of the Accounts Payable service.
Payroll	Reasonable	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Recruitment Services	Reasonable	The overall objective of this audit was to assess the adequacy and effectiveness of systems and controls for the management of Recruitment Services.
Procurement	Reasonable	Review of national sourcing procurement activity within the new integrated procurement teams to establish consistency in processes and assess compliance with procurement guidance.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2022, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline Scope
Switching Services	Reasonable	A review to identify significant single points of failure within switching services and to ensure mitigating action plans have been put in place.
Embedding the Stakeholder Engagement Plan	Reasonable	To provide an opinion over the arrangements for the management of the Stakeholder Engagement Plan within DHCW.
Centre of Excellence	Reasonable	To provide an opinion over the controls for the establishment of the Office 365 Centre of Excellence.
Technical Resilience	Substantial	A review to evaluate the level of technical resilience including interfacing responsibilities and to identify any hardware single points of failure. A sample of incidents will be selected, and a root cause analysis undertaken.
Cyber Security Improvement Plan	Substantial	To provide an opinion over whether appropriate progress has been made with the improvement plan.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline Scope
WHSCC – Quality Unit	Substantial	To evaluate and determine the adequacy of the systems and controls in place within WHSSC in relation to quality assurance reporting.

WHSSC – Neurosciences and long term conditions	Substantial	To evaluate and determine the adequacy of the systems and controls in place for the Neurosciences and Long-Term Conditions Programme.
EASC – Ambulance handover improvement arrangements	Substantial	We focused on the adequacy of the systems and controls in place within EASC for the development of the seven Welsh health boards' ambulance handover improvement plans and their Integrated Commissioning Action Plans (ICAPs) and ongoing monitoring.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2022/23 operational audit plan.

The audit plan approved by the Committee in April 2022 contained 27 planned reviews. We amalgamated the Access to Primary Care audit with the Neighbourhood Care Networks audit, due to significant overlap in audit scopes. We also replaced the Urgent Care System and Quality Framework audits with the Contract Management and Putting Things Right audits, respectively. These changes were reported to and approved by the Audit, Risk and Assurance Committee. As a result of these agreed changes we

have delivered 26 reviews, plus six capital audits completed as part of the integrated audit plan. There were no deferred audits this year.

The assignment status summary is reported at Section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. These are reported quarterly.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2022/23	G	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	72%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 32 reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings

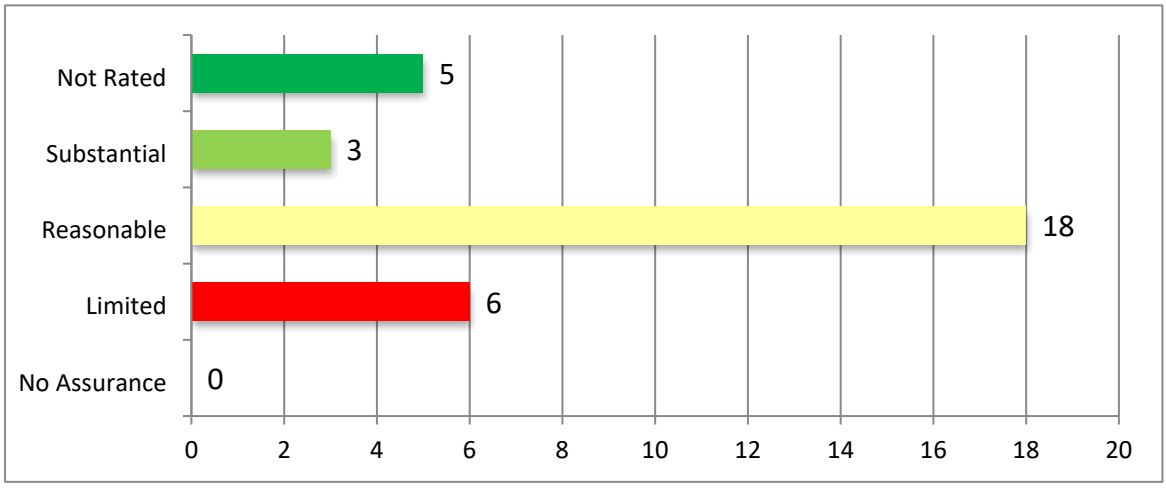


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Digital Benefits Realisation	To consider whether the organisation has an appropriate framework and process to ensure that benefits are gained from investment in digital solutions.
Cyber Security	To provide assurance that the organisation is working to improve its cyber security

Review Title	Objective
	position, and that appropriate reporting is in place that shows the current status.
Grange University Hospital	The overall objective of this audit was to determine the adequacy of information provided in support of the Stage 4 (construction) defined costs claimed by the Supply Chain Partner (through selective testing of the account).

5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk Management	To provide an opinion on the effectiveness of the risk management arrangements in place within a sample of Divisions.
Financial Sustainability	We reviewed the key financial management controls within the Health Board including the development and monitoring of savings programmes required for financial sustainability.
Neighbourhood Care Networks (NCNs)	To provide an opinion on the effectiveness of the controls in place to improve access to primary care services through the NCNs.
Mental Health Transformation	To assess the arrangements in place to implement and provide transformational programmes of work for mental health services and to bring care closer to home.

Review Title	Objective
Dementia Services	To ensure that the Health Board has an appropriate process for Dementia Services for its hospital patients.
Infection Prevention and Control	To ensure that the infection control processes are adhered to on a sample of hospital wards and that appropriate governance arrangements are in place.
Integrated Wellbeing Networks	To provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region, including mental health provision.
Job Evaluation Process	To provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook and is being applied effectively by the Health Board.
Monitoring Action Plans	To review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE)).
Management of the Robotic Process Automation	To ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.
IT Strategy	To ensure that the organisation has developed an appropriate target operating model to enable the delivery of the Digital Strategy.
YYF Breast Care Services	The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit.
Newport East	The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the

Review Title	Objective
	performance to date against its key delivery objectives i.e. time, cost and quality.
Satellite Radiotherapy Centre	The audit was undertaken to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives.
Endoscopy Services	The audit was undertaken to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project, and the performance to date against its key delivery objectives.
Children and Young People's Continuing Care	To consider the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Health Board.
Review of Bank Office and Temporary Staff	To provide an opinion on the operational management of the Bank Office and temporary staff.
Contract Management	To assess the operational management of a sample of Health Board specific contracts.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Corporate Governance (Policy Management)	The audit was undertaken to review the process for the management of policies throughout the Health Board.

Review Title	Objective
Clinical Audit	The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.
Use of Off-contract Agency	To assess whether off-contract agency processes are adhered to, and related expenditure is appropriately monitored.
Discharge Planning	To provide an opinion over the discharge planning process of the Health Board. We focussed on the management and delivery of planned discharges and undertook sample testing of patients admitted during April and May 2022.
Records Management	The review sought to provide assurance that the Health Board has an appropriate process for the management of records which ensures that it is compliant with legislation.
Bevan Health and Wellbeing Centre	The audit sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance

definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Agile Delivery	To assess the Health Board's progress in developing agile working practices and identification of good practice.
Follow-up of High Priority Recommendations	To assess if high priority (and other significant) recommendations from within an appropriate period had been implemented, together with the Recommendation Tracker being updated accordingly.
Decarbonisation	To determine if the Decarbonisation Action Plans (DAP) had been implemented.
Clinical Futures – Care Closer to Home	To assess the overall objective of implementing care closer to home.
Putting Things Right	This advisory review assessed if there were alternative approaches or processes to strengthen the putting things right service within the Health Board.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reports issued. Therefore, the conclusions of our audit work have been taken into account for the 2022/23 Head of Internal Audit Opinion. Overall, there is no adverse impact on the Opinion.

Review Title
Review of Bank Office and Temporary Staff
Putting Things Right

5.8 Deferred Audits

There were no deferred audits this year.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the organisation to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Stephen Chaney
Actio Pennaeth yr Archwiliad Mewnol/Acting Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
June 2023

Appendix A

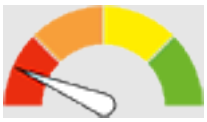
ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit, Risk and Assurance Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit, Risk and Assurance Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational

	plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit, Risk and Assurance Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit, Risk and Assurance Committee. An annual report and opinion is produced for the Audit, Risk and Assurance Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed

	management actions. This is reported to the Audit, Risk and Assurance Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Archwilio Cymru
Audit Wales

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: July 2023

Document reference: 3503A2023

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

About this document

1 This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Audit General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Planning	Rob Holcombe – Director of Finance and Procurement	This work involves undertaking risk assessment procedures to identify risks of material misstatement within your financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk.	Completed	Detailed Audit Plan 2023 presented to the committee in May 2023
Audit of Accounts	Rob Holcombe – Director of	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to	Draft accounts received 5 May. The audit is	Audit of Accounts Report to be presented to

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Finance and Procurement	Auditor General to provide his opinions on the financial statements of the health board.	substantially complete.	committee at July 2023 Audit. Risk and Assurance Committee
Charitable Funds: • Planning • Audit of Charitable Fund Financial Statements	Rob Holcombe – Director of Finance and Procurement	• This work involves undertaking risk assessment procedures to identify risks of material misstatement within the Charitable Fund's financial statements. The subsequent design and performance of our audit approach will be responsive to each assessed risk. • We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinion on the financial statements of the Charitable Fund.	Not yet started	To be confirmed

Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Core	Nicola Prygodzics – Chief Executive Officer	• Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment work will review: Board and committee effectiveness, cohesion, and transparency; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning, management, and performance arrangements.	Set-up stage	November 2023

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep Dive	To be confirmed	In addition to the core structured assessment work described above, we will also review certain arrangements at NHS bodies in more depth. This year, we will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency	Planning	To be confirmed
Unscheduled Care Arrangements	Leanne Watkins – Director of Operations / Chris O'Connor – Interim Executive Director of Primary Care, Community and Mental Health	This work has been carried forward from the 2020 Audit Plan and will initially look to provide a high-level whole system overview of the unscheduled care. The overview will be informed by the development of an interactive database covering all aspects of the unscheduled care pathway. Further work will then be undertaken on specific elements of unscheduled care pathway, with a likely focus on activities to signpost patients to the most to appropriate care setting, and to manage patient flow through the system.	Reporting	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Follow-Up of Primary Care Services	Chris O'Connor – Interim Executive Director of Primary Care, Community and Mental Health	Follow-up of recommendations made in our Primary Care services review	Reporting	September 2023
All-Wales thematic on workforce planning arrangements	Sarah Simmonds – Executive Director of Workforce and Organisational Development	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. The work will be tailored to align to the responsibilities of individual NHS bodies in respect of workforce planning.	Fieldwork	September 2023
Quality Governance Review Follow up	Jennifer Winslade – Executive Director of Nursing	The work will assess the extent to which previous audit recommendations arising from our thematic review of Quality Governance arrangements have been implemented and are delivering the	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	James Calvert – Medical Director Peter Carr – Executive Director of Therapies and Health Sciences	intended outcomes / benefits. It will also focus on the Health Board's preparedness for the Duty of Quality and Candour and the effectiveness of its governance arrangements in providing assurance over its compliance.		

Other relevant publications

6 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Digital Inclusion in Wales and Key questions for public bodies	March 2023

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Forward work programme | Audit Wales	May 2023

There are no relevant Audit Wales consultations currently underway.

Audit Wales

1 Capital Quarter, Tyndall Street,

Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	19 July 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Report and Accounts 2022/23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In respect of the Annual Report and Accounts 2022/23, this paper presents to the Board the final draft audited versions of:

1) The Performance Report (Part 1)
2) The Accountability Report (Part 2), including:
   a) A Corporate Governance Report
   b) A Remuneration and Staff Report
   c) A Parliamentary Accountability and Audit Report.

for consideration and approval prior to being submitted to Welsh Government on 31st July 2023, in-line with HM Treasury Requirements.

Following presentation of the draft documents to the Audit, Risk and Assurance Committee on 23rd May 2023, the final draft versions incorporate comments and feedback received from Welsh Government; Audit Wales; and Board Members, including those comments made by the Audit, Risk and Assurance Committee when reviewing the drafts.

Page numbers contained in the documents will be added once the 3 reports have been combined in to one consolidated document for submission.

Part 3 of the Annual Report and Accounts 2022/23 are the Financial Statements 2022/23, and these are provided to the Audit, Risk and Assurance Committee under separate cover.

Cefndir / Background

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by Welsh Ministers and the approval of the Treasury.

The Manual for Accounts, issued by Welsh Government, has been prepared to ensure that those determinations and directions are consistent with the 2022-23 Government Financial Reporting Manual (FReM) which sets out the accounting guidance applicable to bodies within the Resource Accounting Boundary. In setting the requirements of the FReM the government is advised by an independent body, the Financial Reporting Advisory Board (FRAB). NHS bodies are required to follow FReM guidance except where a divergence has been formally agreed with the Treasury.

The Manual provides principles–based guidance to NHS bodies on how to prepare and complete their annual report and accounts and financial returns. Application of the principles to the individual circumstances of a NHS body is a matter between the body and its external auditors.

The Annual Report and Accounts as a whole must be fair, balanced and understandable and the Accountable Officer takes personal responsibility for it and the judgments required for determining that it is fair, balanced and understandable.

Asesiad / Assessment

Annual Report and Accounts – Requirements for 2022/23

As set out in the Manual for Accounts, NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

- The Performance Report, which must include:
  - An overview.
  - Performance analysis

- The Accountability Report, which must include:
  - A Corporate Governance Report.
  - A Remuneration and Staff Report.
  - Senedd Cymru/Welsh Parliament Accountability and Audit Report.

- The Financial Statements, including:
  - The Audited Annual Accounts 2022-23.

The detailed structure of the Annual Report and Accounts 2022/23, is set out at Annex A.

For the 2022-23 reporting period the deadlines for submission are:

Annual Reports 2022/23 - Key Dates	**2022**	
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	**Fri**	**12-May**
AARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tue	**23-May**
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	**18-July**
Board meeting to approve Final Accounts and Accountability Report	Wed	**19-July**
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Mon	**31-July**
Annual General Meeting – to receive the Annual Report and Accounts	Wed	27-Sept

Part One – The Performance Report 2022/23

The purpose of the performance section of the annual report is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013, No. 1970. The main features of the performance report should flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against that plan in the year of reporting.

The performance report must provide a fair, balanced and understandable analysis of the Health Board's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable.

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Performance Report was considered by the Audit, Risk and Assurance Committee on 25th May 2023, where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft performance report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft. Welsh Government has also reviewed the draft performance report and, as with Audit Wales, updates to the document have been made to reflect feedback and comments received.

Part 2 – The Annual Accountability Report 2022/23

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The Accountability Report is required to have three sections:

- Corporate Governance Report

The purpose of the Corporate Governance Report is to explain the composition and organisation of the Health Board's governance structures and how they support the achievement of the entity's objectives.

As a minimum, the corporate governance report must include:

  - The Directors' Report;
  - The Statement of Accounting Officer's responsibilities; and
  - A Governance Statement.

The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control.

- Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

- Senedd Cymru/Welsh Parliament Accountability and Audit Report

The Parliamentary Accountability Report contains disclosure on the following:

- Regularity of expenditure
- Fees and charges
- Public Sector Information Holders only - a statement is required if the entity has not complied with the cost allocation and charging requirements set out in HM Treasury guidance
- A brief description of the nature of each of the organisation's material remote contingent liabilities (that is, those that are disclosed under Parliamentary reporting requirements and not under IAS 37) and, where practical, an estimate of its financial effect. (This is included in the Annual Accounts [Part 3]).

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Accountability Report was considered by the Audit, Risk and Assurance Committee on25th May 2023 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft Accountability report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft. Welsh Government has also reviewed the draft accountability report and, as with Audit Wales, updates to the document have been made to reflect feedback and comments received.

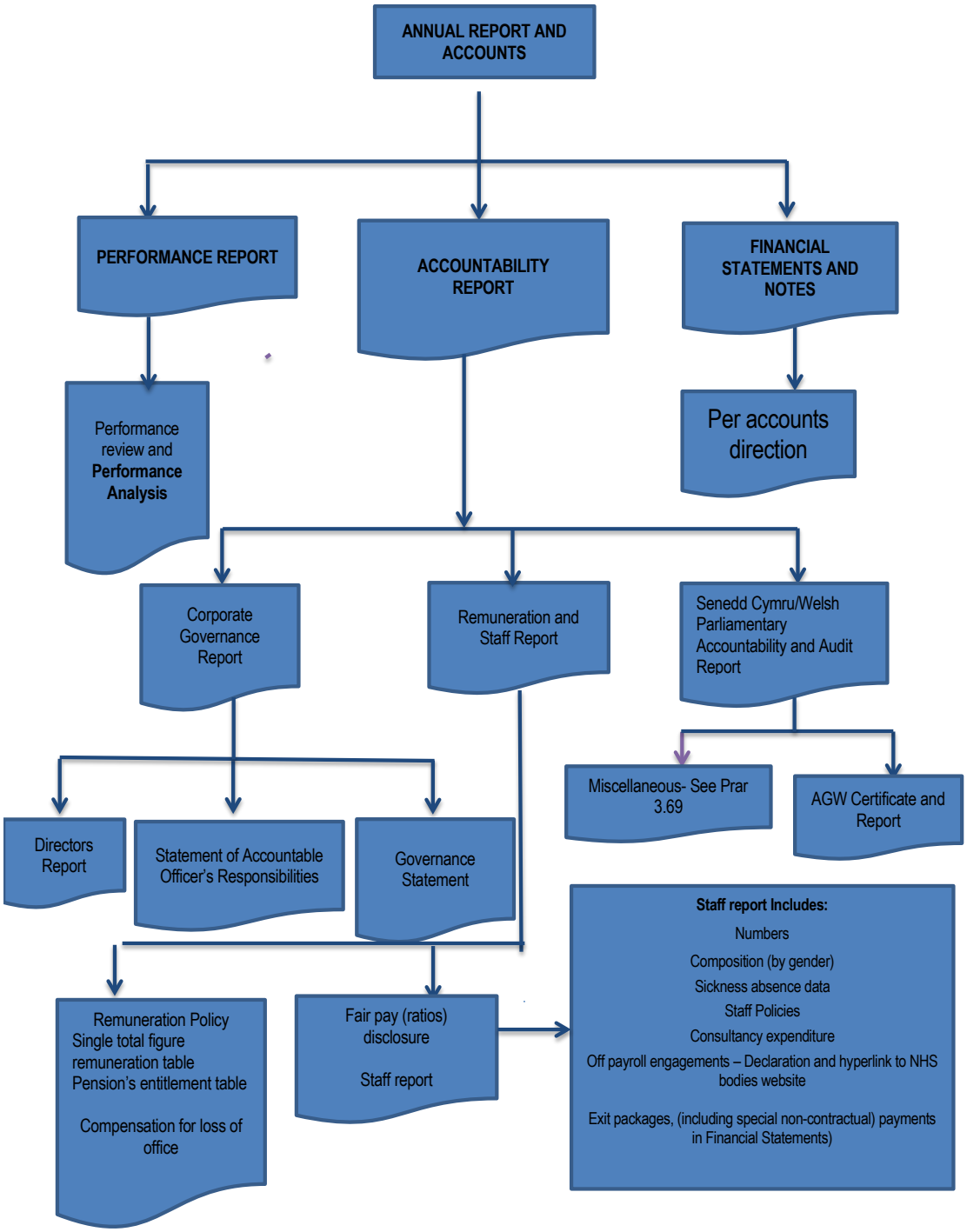
Material changes made since the first draft are highlighted in yellow within the attachment to support committee members in undertaking their final review. Attachment One provides an overview of the comments received and changes made.
Argymhelliad / Recommendation The Audit, Risk and Assurance Committee is asked to CONSIDER and REVIEW the Final Draft versions presented prior to being submitted for formal approval by the Board on 19th July 2023.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Audit, Risk and Assurance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.


ANNUAL REPORT AND ACCOUNTS
PERFORMANCE REPORT
ACCOUNTABILITY REPORT
FINANCIAL STATEMENTS AND NOTES
Performance review and **Performance Analysis**
Per accounts direction
Corporate Governance Report
Remuneration and Staff Report
Senedd Cymru/Welsh Parliamentary Accountability and Audit Report
Miscellaneous- See Prar 3.69
AGW Certificate and Report
Directors Report
Statement of Accountable Officer's Responsibilities
Governance Statement
Remuneration Policy
Single total figure remuneration table
Pension's entitlement table
Compensation for loss of office
Fair pay (ratios) disclosure
Staff report
Staff report Includes:
Numbers
Composition (by gender)
Sickness absence data
Staff Policies
Consultancy expenditure
Off payroll engagements – Declaration and hyperlink to NHS bodies website
Exit packages, (including special non-contractual) payments in Financial Statements)

Attachment One

Comment	Page	Action
Performance Report		
Performance measures – are there comparators, what was it before?	8	Updated with comparator dates
Reduction in complaints and Increase use of ACP – states no data – why not?	16	changed to 'indicator to be developed' rather than there being no data available. Work underway to develop reporting for Q1.
Accountability Report		
Use of Board Secretary/Director of Corporate Governance – inconsistency through document		Updated – Director of Corporate Governance
EQIA - *currently reviewing our current Equality Impact Assessment (EqIA) process* – add in timescales for this	45	• Evaluation of current process (to be completed by July 2023) • Development, testing and launch of a screening tool to come to decision about whether and why further analysis is - or is not - required (to be completed by August 2023). • Refinement of EQIA documentation (to be completed by August 2023). • Development of guidance (to be completed by September 2023). Amended narrative to include September 2023
Monitoring audit recs - *challenging owing to the impact of COVID-19 on the organisation* – this needs to be amended as wider than just COVID	56	Amended to: *due to the sustained challenges on the system and staffing, the Health Board has been required to balance risk across the system which has, at times, resulted in delays in implementing audit recommendations.*
Staff and Remuneration Report		
Staff numbers: Increase admin/decrease in nursing - include a statement in the report to caveat this	97	Revised staff numbers show reduction in admin and increase in nursing

Comment	Page	Action
Tax Assurance Off Payroll – table includes blanks, should they be 0?	101	Updated
The Health Board has approved VERS in 2021/22 – should this be 2022/23?	102	Updated
Financial Recovery		
add a paragraph around 2023/24		Added to document

Comments from Audit Wales

Page Ref	Query/Observation	Response
	Performance Report	
5	Image in shaded box relates to 2014 data – suggest HB updates the information to make it relevant	Removed and replaced with link to Area Needs Assessment
5	Last but one para – refers to WG budget of just over £1.6bn – this is different to what the foreword of the accounts states and a query has already been raised with HB so just need to make sure the correct figure is reflected in both the AR and the foreword	WG funding £1,667,210,000 so just over £1.6bn – Accounts to be amended to read this
35	Section 10 – PSPP % stated differ from the figures in Note 10 to the accounts	Confirmed correct
	Accountability Report	
8-10	Need to check that details included here reconcile to those within the Rem Report, in case changes are made to Rem Report following audit. Inconsistencies noted as follows: • Glyn Jones - Interim Chief Exec per Rem report is until 4/9/23 & Deputy Chief Executive is from 5/9/22 to 23/9/23 • Christopher Dawson- Morris - Rem report shows Interim director of planning & performance from 5/9/22 but no end date shown.	Amended in AGS AGS states end date of 03/04/23 - to be amended in rem report

	• Hannah Evans -not shown in Rem report as from 1/4/23.	AGS includes info to the point of publication, Rem report up to 31/3
	• Linda Alexander - Rem report shows from 25/6/22 to 14/8/22 & not 15/8/22	Change form states 15/08/23 as start date of return to assistant post. AGS amended to 14/08
	• Peter Carr - no dates shown in Rem Report. •	Dates not needed – in post full year
	• Tracy Daszkiewicz - Director of public health - not shown in Rem report as from 1/4/23.	AGS includes info to the point of publication, Rem report up to 31/03
	• director of social services - not shown in Rem report ??	Post vacant full year
	• Associate members - Keith Sutcliffe - consistent	Keith in post until 30/11/22
	• Chair of health professional's forum - vacant - not clear in Rem Report - shows interim vice vacant	HPF Chair vacant for the full year. Pippa Britton has been interim vice chair for the full year - this is reflected in rem report. Unclear where the report states interim vice chair vacant
10	Throughout Report there are references to the 'Board Secretary' however on page 10 it mentions that the Board secretary's title has been changed to Director of Corporate Governance on14 March 2022 so shouldn't the HB be using the new title throughout the 22-23 AR?	Updated to read DoCG

17& 20	ARAC and Charitable Funds section – no reference to Audit Wales 'Audit of Accounts Report'. Or are these referred to somewhere else – I couldn't see them?	Added
29	Last para should state 31 March 2023?	Amended
32(i)	First para, last sentence – by the time this AR is published the first quarter would have been and gone so narrative needs to be updated to indicate whether this happened or not.	Changed to Q2
33	Top of page – same issues as 32(i) above	Changed to Q2
34	Second para – same issue as 32(i) above	Changed to Q2
35	Third para – refers to a reported y/e deficit of £37m yet in para 4 talks about reducing forecasted y/e deficit to reported deficit of £37m – what is the 'forecasted t/e deficit figure?	Amended: This recovery programme was expected to deliver opportunities to achieve the forecast deficit to the reported forecast of £37m deficit,
43	Last para – states that the 22-26 IMTP requires strengthening @WG and that updated IMTP will be resubmitted by 31 May 2023. (i) So does this mean the HB has not had its most recent IMTP approved by WG and therefore not met it's financial duty? (ii) Needs to be updated re submission date given 31 May now passed	Section updated
45	Last paragraph – is year on year saving of 3.1% a financial saving or a carbon saving – not clear from narrative	Confirmed carbon saving – included in report
49	List of o/s IA Reports as at April – many presented to May ARAC and so this needs updating	2 IA reports presented in May –Expansion of endoscopy services and Sat. Radiotherapy Centre. Narrative amended to as at May. These 2 removed

		from the list and added to the reasonable assurance section 6 outstanding IA reports will be reported to Committee in July and these will be added to the AGS. Leaving 2 outstanding reports
49-55	IA reports – for those with limited assurance, the HB should provide details of actions taken to address the weaknesses	Section updated
67	Shaded boxes – were these meetings really non-quorate – looks odd the way it is shown (well at least on my b&w printed version)	This is a B&W issue – they are blacked out as there was no meeting, not due to quoracy (as different committees meet on a different number of occasions)
88-102	AW greed with DoF and ADoF that an additional disclosure note is to be included regarding the payments to the two former ChExecs who are on secondment to WG	Actioned

Aneurin Bevan University Health Board Annual Report and Annual Accounts 2022/23

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2022/23, what we have achieved, how we plan to continue to improve next year and our plans for the future. This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2022 to 31st March 2023 includes:

- Our **Performance Report** which details how we have performed against our targets and the actions planned to maintain or improve our performance.

- Our **Accountability Report** which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.

- Our **Financial Statements and Annual Accounts** which detail how we have spent our money and met our obligations.

Contact Us

You can contact the Health Board using the details below:
Aneurin Bevan University Health Board
Headquarters, St Cadoc's Hospital
Lodge Road, Caerleon, Newport, NP18 3WQ
Telephone; 01633 436700 or email abhb.enquiries@wales.nhs.uk
http://twitter.com/aneurinbevanhb
https://www.facebook.com/AneurinBevanHealthBoard

Performance Report

1. Overview form the Chief Executive

Over the past twelve months our organisation has remained under sustained operational pressure at levels that, pre-Covid 19, would only have been seen in the winter period. 2022/23 brought increases in demand across our urgent and planned care systems, increased pressure on primary care and community services, as well as mental health services. We have continued to experience high walk-in demand at our emergency departments, significant pressures in social care and high levels of sickness and absence across our workforce. The sustained urgent care pressures together with challenges faced by the social care system continue to impact on service recovery.

Despite these challenges there have been improvements in performance, across the breadth of our priorities, as we seek to return to pre-pandemic levels of service and deliver the service transformation that underpins our plans to deliver a sustainable system of care for the future.

The Health Board's Integrated Medium-Term Plan (IMTP) for 2022/25 set out our core organisational priorities, underpinned by our focus on reducing health inequalities experienced by our communities, through improving population health. In doing so, the plan adopted a life course approach that optimised the health and wellbeing of our population, building on an approach first adopted in 2021. We are confident that this approach, over the long term, will provide high returns for health and sustainable development, both by limiting the accumulation of risks throughout life and associated ill-health for our citizens. Maintaining the focus on the long term is challenging in the face of operational pressures but vital in charting a course to sustainability. Our plan was underpinned by three core themes, optimism, realism and sustainability.

- **Optimism** stemming from a growing understanding of our system, we know where to focus our efforts, and with our renewed strength in partnership working, improved infrastructure (facilities and technology) together with our workforce have and continue to demonstrate that we can deliver change at pace to improve care.
- **Realism** - our priorities and delivery profiles (set out in the Minimum Data Set) were developed with frontline clinical teams. Through our dynamic planning approach we have a good understanding of potential demand, risks and capacity requirements for clinical teams and for our system.
- **Sustainability** - our plan focused on delivering the actions to maximise sustainable capacity, support people in the most appropriate place of care, and take preventative actions to help people live well in our communities.

Our Clinical Futures Strategy with tackling health inequalities at its core, has remained resilient and relevant for over a decade. Since the opening of the Grange University Hospital in November 2020 (a fundamental milestone in the delivery of the broader strategy) we have reshaped our Clinical Futures Programme to support the delivery of the Health Board's key organisational priorities which, based on our understanding of our system, will have the biggest impact on improving the sustainability of our system.

Dyfodol Clinigol Clinical Futures

Aneurin Bevan University Health Board – 10 Priority Programmes 2022/23

- Public Health Protection & Population Health Improvement
- Accelerated Cluster Development (placed based health and care)
- Redesigning Services for Older People
- Transforming Urgent & Emergency Care
- Planned Care Recovery
- Maximising Cancer Outcomes
- Transforming Mental Health Care
- Reconfiguration of enhance Local General Hospital Network
- Decarbonisation
- Agile Working

The following areas highlight some of the key achievements from 2022/23.

Improving the Health of our Population

In 2022/23 we were successful in establishing Gwent as a Marmot region (along with our Local Authority partners), which confirms our commitment to tackling health inequalities and launching the five-year Gwent Well Being Plan 2023-28.

Once again, we achieved exceptional childhood vaccination performance, with 94% of children receiving the '6 in 1' vaccination by the age of one and 90% of children receiving two doses of MMR by the age of five.

We also continued making great progress in reducing smoking prevalence across Gwent and we also have lots of great examples of supporting patients and citizens to lead a healthier lifestyle.

Primary Care Services

Face-to-face consultation rates were up to 58% in April 2023 (from 25% in June 2021). It's encouraging that 46% of GP practices are now using digital systems (such as Attend Anywhere and E-Consult) and our Dental Services have seen over 30,000 new patients.

Our pharmacies have continued to play a critical role in our primary care system, with all community pharmacies now signed up to provide key services such as Common Ailments Scheme (up 76% from 21/22) and flu vaccinations. In addition, we have also seen an increase in the number of pharmacies that can independently provide a prescription service.

Urgent and Emergency Care System

The last year continued to be an exceptionally busy year, with the number of patients accessing our urgent care services reaching unprecedented levels. To help alleviate the pressure we saw the establishment of the Same Day Emergency Care (SDEC) unit at The Grange University Hospital and Ysbyty Ystrad Fawr, alongside the launch of the new ambulatory care services in respiratory, gynaecology and gastroenterology.

We have also been working hard with our Local Authority colleagues as to how we can reduce discharge delays for patients waiting to leave hospital and how we can support older people better in their own homes and avoid hospital admissions. Our Care with GRACE (Gwent Rapid Access Clinic for the Elderly) is one example of this; the clinic now operates on weekdays and provides a holistic assessment within 24 to 72 hours of referral.

Planned Care and Cancer Services

Great progress was made during 2022/23 in reducing the backlog of patients waiting for diagnostic tests, outpatient appointments and operations, especially those who had been waiting more than 2 years for treatments.

We have increased the number of operations and outpatient appointments undertaken and are now closer to or above the levels we were operating at pre-pandemic.

We have also seen an improvement in cancer performance and have reduced the number of patients waiting, despite increasing referrals. We have also improved access to cataract surgery, as result of regional working with neighbouring Health Boards.

Mental Health Services

The introduction of the 111 (Press 2) service now offers urgent mental health support and advice to our patients and communities 24-hours-a-day, seven days a week, supporting the most vulnerable in our communities.

Our Peer Mentors Service was recognised as ‘best practice’ by Welsh Government. Changes to the Psychology Service has also improved patient choice and we have seen a number of other innovations focussing on mental wellbeing, such as the 'Recovery Through Sport' programme and 'Project Wingman' (the wellbeing bus).

There has also been huge progress in our Child and Adolescent Mental Health services (CAMHS), with some great initiatives working with schools and significant efforts to reduce the waits for assessment.

Strategic Developments

Our new Breast Unit was approved and is now under construction at Ysbyty Ystrad Fawr, with construction due to complete in December 2023 and the unit opening early in 2024.

Construction has also commenced on the Satellite Radiotherapy Unit at Nevill Hall Hospital, which is due to open in 2025.

The new Endoscopy suite at the Royal Gwent Hospital is also under development and due to open later this year, which will create a four-room facility to support improved patient access and a reduction in waiting times.

Dedicated accommodation for NICU parents at The Grange University Hospital was officially opened this year to help provide added support to families with very poorly babies.

Our Workforce

Our People Plan 2022-25 was approved which focuses on staff health and wellbeing, workforce sustainability and being the employer of choice. There has been a continued focus on recruitment and retention, a reduction in agency usage in the last quarter and an enhanced focus on employee wellbeing and staff recognition.

Finance

Despite a hugely challenging environment, we ended the last financial year with an overspend of £37m. This was the first year the Health Board had not delivered a break-even position. However, whilst this was disappointing, at month six the forecast deficit was much greater and it was through the efforts of our staff and a renewed focus on efficiency that enabled us to keep the overspend to the £37m.

Despite all the financial challenges and service pressures that we continue to face, it is important to acknowledge the huge progress made over the last year.

Moving forward into 2023/24, we have plans in place to build on the progress made last year across our priority areas and further improve access and quality of services. However, we face the most significant financial challenge and we will need to further develop our services to make them even more effective and efficient.

2. Reporting Requirements

The purpose of the Performance section of this Annual Report 2022/23, as set out in the guidance provided in the NHS Wales 2022/23 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives and strategies and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of the performance report flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against these.

It should be noted that the duty of quality comes into legal force in April 2023 in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The new reporting requirements will therefore be captured through processes in place for 2023/24. In the interim, a non-statutory implementation of the duty of quality was introduced in autumn 2022. This will allow for testing the quality reporting indicators and qualitative measures being developed during the duty of quality implementation phase as a hybrid reporting process for 2022/23. Further information is available in the Annual Accountability Report, Page XX.

The Annual Accountability Report (Section 2), Page XX, includes an overview of the Health Board's work in relation to its Sustainability and Carbon Reduction Plans, with some detail also included below at page 23.

3. Aneurin Bevan University Health Board

Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

As a Health Board, we serve the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the south Wales valleys.

The Population Needs Assessment for the region can be found here: Demography - Gwentrpb

The Health Board employed 12,648 whole time equivalent (WTE) staff as at 31st March 2023. It is the largest employer in Gwent. Our workforce is ageing, as is the demographic profile of our population and the health inequalities of our population are also found within our workforce. 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans.

The Health Board has an annual budget from the Welsh Government of just over £1.6 billion per year from which we plan and deliver services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2022/23).

4. Integrated Medium Term Plan 2022/23 – Life Course

The IMTP 2022/23 set out the Health Board's priorities based on adopting a life course approach. Unlike a disease-oriented approach, which focuses on interventions for a single condition often at a single life stage, the life course approach considers the critical stages, transitions and settings where differences can be made in promoting or restoring the health and wellbeing of both current and future generations. This approach requires working with our citizens (as individuals, families and communities) to deliver the change our communities need.

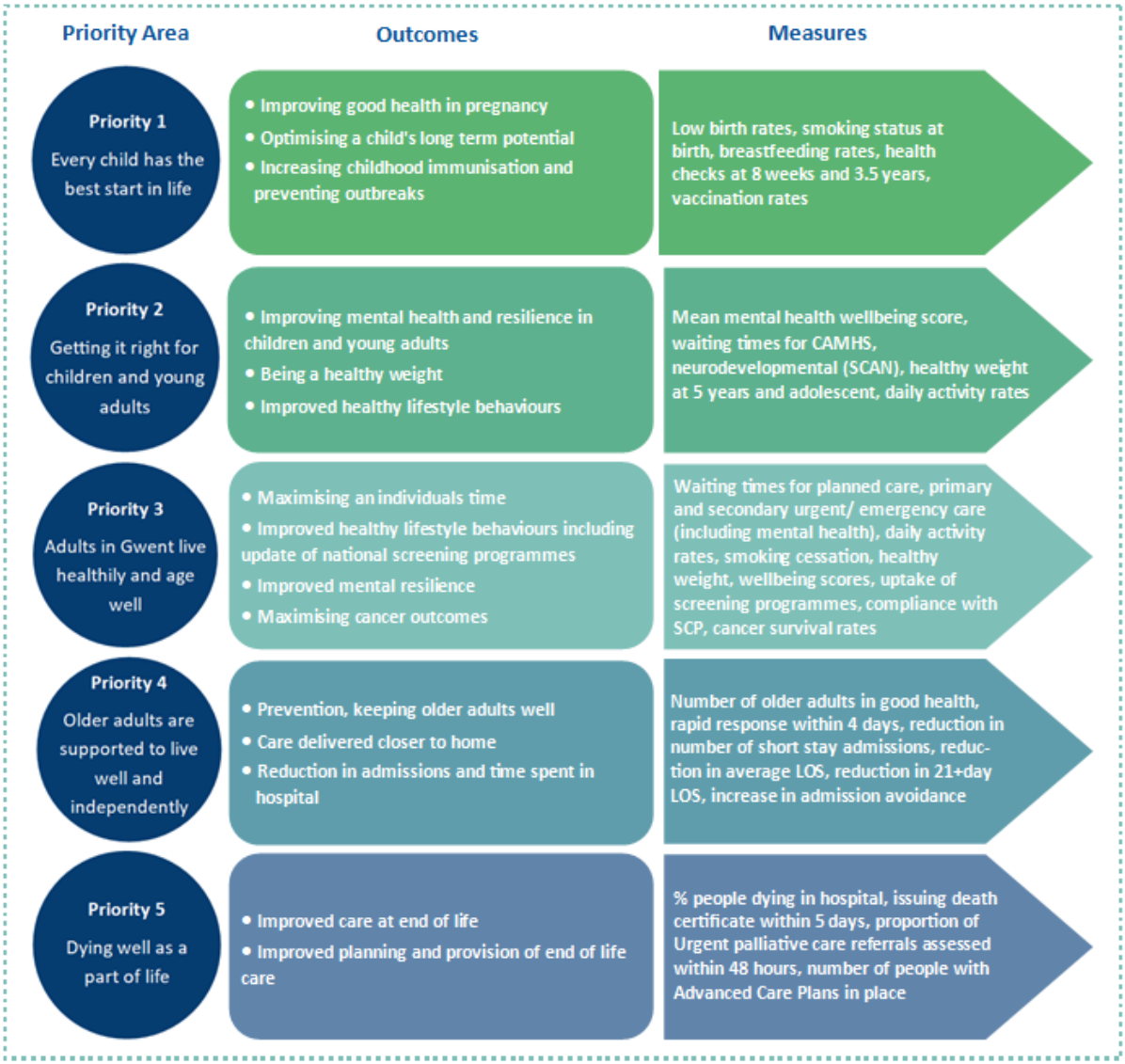
This approach requires holistic, long-term policy and investment strategies that promote better health outcomes for individuals and greater health equity in the population. We are confident this approach can provide good returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development.

We know that the direct and indirect harms of Covid-19 have amplified health inequalities for our population, further heightened by the cost-of-living crisis. Balancing our efforts to respond to the substantial and unprecedented demand for urgent, emergency and routine health services and embedding our life course approach has been a key challenge this year and will remain a challenge as we approach 2023/24.

Over the past year we have developed a set of supporting measures for each stage of the life course, together with 43 associated indicators that

help us to monitor and measure the progress that we are making and the impact of our actions on the health and wellbeing of our population.

Our Outcomes Framework



Delivering the IMTP Priorities 2022/23

Priority 1

Every child has the best start in life

Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board's IMTP committed us to working with partners to take forward actions and activities that have a positive impact on the first 1000 days of life. We seek to deliver three outcomes, and an overview of our progress in 2022/23 is shown in the table below.

Our Commitments	Our Measures	Our Performance
Improving Good Health in Pregnancy 	Decrease Low Birth Rates	Improving (5.6% 2020 to 5.1% 2021)
	Decrease smoking rates @ birth	Improving (16% to 13.7%)
	Decrease still births	Improving (4.8% to 3.9%)
Optimising a child's long term potential 	Increase uptake of women breastfeeding	Similar (56.6%)
	Increase eligible children measured and weighed at 8 weeks	Deteriorated (62.5 to 28.3%)
	Increase of eligible children with contact at 3.5 years (preschool)	Deteriorated (64.4 to 42.1%)
Increasing childhood immunisation 	% Children who received 2 doses of MMR by age 5	Similar (90%)
	% Children who receive 3 doses of hexavalent '6in1' vaccine by age 1	Similar (94%)

Whilst our targets for optimising a child's long-term potential have not been met, largely because of significant workforce challenges, the Health Board is making good progress in implementing its local plans to increase contact in line with the overall Welsh Performance levels.

Priority 2

Getting it right for children and young adults

Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; targeting actions to improve outcomes in these areas has a long-lasting impact on delivery and development. Young adult mental health is a Ministerial priority area with CAMHS a priority in the national performance framework. We seek to deliver three outcomes, and an overview of our progress in 2022/23 is shown in the table below.

Our Commitments	Our Measures	Our Performance
Improve mental health resilience 	Improvement in the mean mental health and wellbeing score for children	Indicator being developed as part of Marmot work
	Decrease in 4-week CAMHS waiting lists	Similar 97.4% at June 2022 unable to provide year end due to change in informatics system
	Increased compliance in neurodevelopmental (SCAN) waiting list	Deteriorated (80% to 42.2%) over the year
Support being a healthy weight 	Increase in children aged 5 a healthy weight	Improving (73 to 75%)
	Increase in adolescents of health weight	Indicator being developed
Improve healthy lifestyle behaviours 	Increase % children (aged 2 – 7 years) who are active for at least 1 hour each day	Similar (63%)
	Increase % of children who eat vegetables each day	Similar (68%)

Increases in demand, together with the restart of face-to-face appointments, has resulted in a backlog of children undergoing neurodevelopmental assessments. The recovery plan working with Local Education Teams, supported by our School-in-reach, school nurses, locality community support services and school staff has seen an improvement in performance, particularly for assessments. Full recovery is anticipated in Quarter 2 of 2023/24.

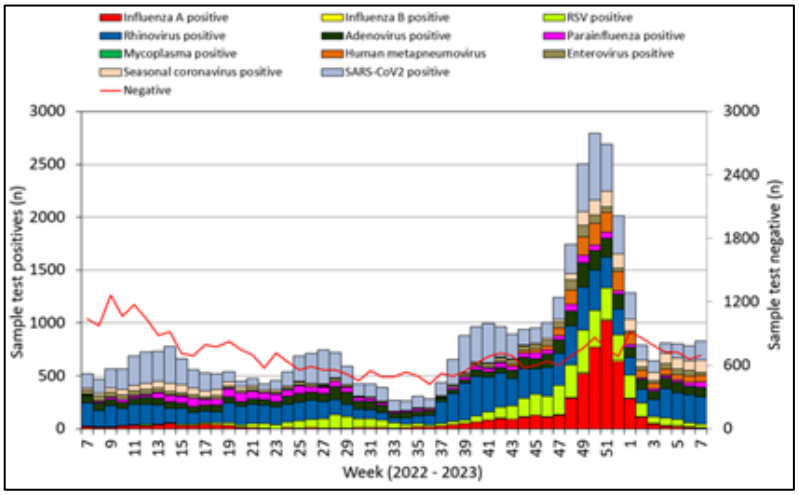
Priority 3

Adults living healthily and ageing well

Our ambition is for citizens to enjoy a high quality of life and to be empowered to take responsibility for their own health and care. A significant number of measures fall within this area. The outcomes and performance set out below underpin the work of 4 of the Health Board's Priority Programmes, spanning transforming urgent and emergency care, planned care recovery, maximising cancer outcomes and transforming mental health care. An overview of our progress in 2022/23 is shown in the table below.

Our Commitments	Our Measures	Our Performance
Maximise an individuals time 	Reduction in the number of patients waiting more than 36 weeks for treatment	Deteriorated (6.6% increase)
	Reduction in the number of patients waiting for a follow-up outpatient appointment	Deteriorated (4.7% increase)
	Increase in Urgent Primary Care Contacts	Improving (148% increase)
	Increase in Think 111 calls	Improving
	Reduction of ambulance handovers over 1 hour	Deteriorated (737 to 846)
	Reduction in patients never waiting in ED over 16 hours	Deteriorated (417 to 498, 19% increase)
	Reduction in time for patients to be seen by first clinician	Deteriorated (1.6 to 2.3 hours)
	Reduction in time for bed allocation from request	Deteriorated (13.9 hours = increase of 20% from baseline
Adults living healthily and aging well 	Increase in adults active at least 150 minutes a week	Similar (51%)
	Decrease in the % of adults smoking	Improved (19% to 12%)
	Decrease in the number overweight or obese adults (BMI over 25)	Similar (67%)
	Increase in working age adults in good or very good health	Similar (69%)
	Increase uptake of National Screening Programmes	Improved (64 to 70.2%)
Maximise cancer outcomes 	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Similar (56%)
	Increase in 5-year cancer survival	Improved (49.1% to 54%)
Improve mental health resilience 	Increase in Mental Health Well-being score for adults	Similar (50.5%)
	Increase % of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Deteriorated (80 – 75%)

Urgent and Emergency Care services continue be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. The end of Quarter 3 and beginning of quarter 4 saw a large number of patients presenting with respiratory viruses – particularly flu and Covid-19. This significant increase in respiratory viruses across our communities also caused high levels of staff sickness which placed additional pressure on urgent care services. In addition to this, there has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity linked to post lockdown impact, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.

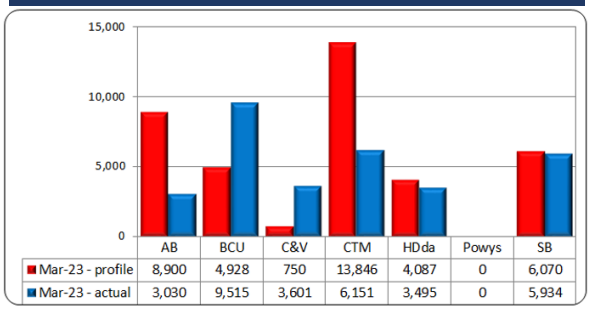


This pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the Grange University Hospital Emergency Department (ED) continues to be above target and increased during January in line with peaks in respiratory illness. We continue to have patients waiting longer than 50 minutes to be transferred to the Emergency Department from an ambulance. This is a result of poor flow through the system for those who need to be admitted. The sustained numbers referred to a specialty but discharged from ED is a key indicator of the pressure across the system.

The extreme pressures upon the urgent care system this winter have impacted on the performance measures of patients waiting under 4 hours and over 12 hours in Emergency Departments. As of March 2023, compliance against patients treated within 4 hours deteriorated from 73.7% (March 22) to 72.5%. During 2022/23, Aneurin Bevan consistently remained the highest performing Health Board across Wales, excluding Powys, and whilst the 95% target has not been met, its performance is significantly higher than the all-Wales average. Additionally, during March, there was an increase in the number of patients waiting over 12 hours from 1,509 (March 22) to 1,606.

Maximising an individual's time is a core element of **planned care**. The Health Board has made considerable progress throughout the year in treating the **longest waiting patients**, i.e. those waiting over 104 weeks. We have achieved and surpassed the 104-week target and have the smallest proportion of patients waiting across Wales.

Patients waiting >104 weeks for referral to treatment

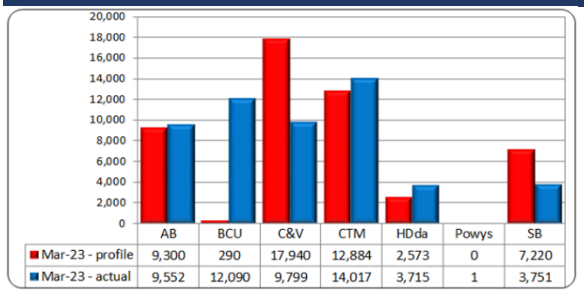


	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-23 - profile	8,900	4,928	750	13,846	4,087	0	6,070
Mar-23 - actual	3,030	9,515	3,601	6,151	3,495	0	5,934

Despite achieving the trajectories, there remain a number of specialty areas with ling waiting times (Orthopaedics, Ophthalmology, and ENT). There continues to be targeted work in all three specialities to treat the longest waiting cohort with the exception on ENT, where the total capacity available for ENT care is less than the capacity to meet the target. For Ophthalmology, a Business Case seeks to provide a 14-month solution to provide additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region has been developed for approval in Quarter1 23/24.

Clinical Specialties are balancing the principle of undertaking activity defined by **clinical prioritisation**, nd a time-based approach for the longest waiting patients; this enables timely care for the most urgent patients and clinically-led decision making.

Patients waiting >52 weeks for new outpatient app



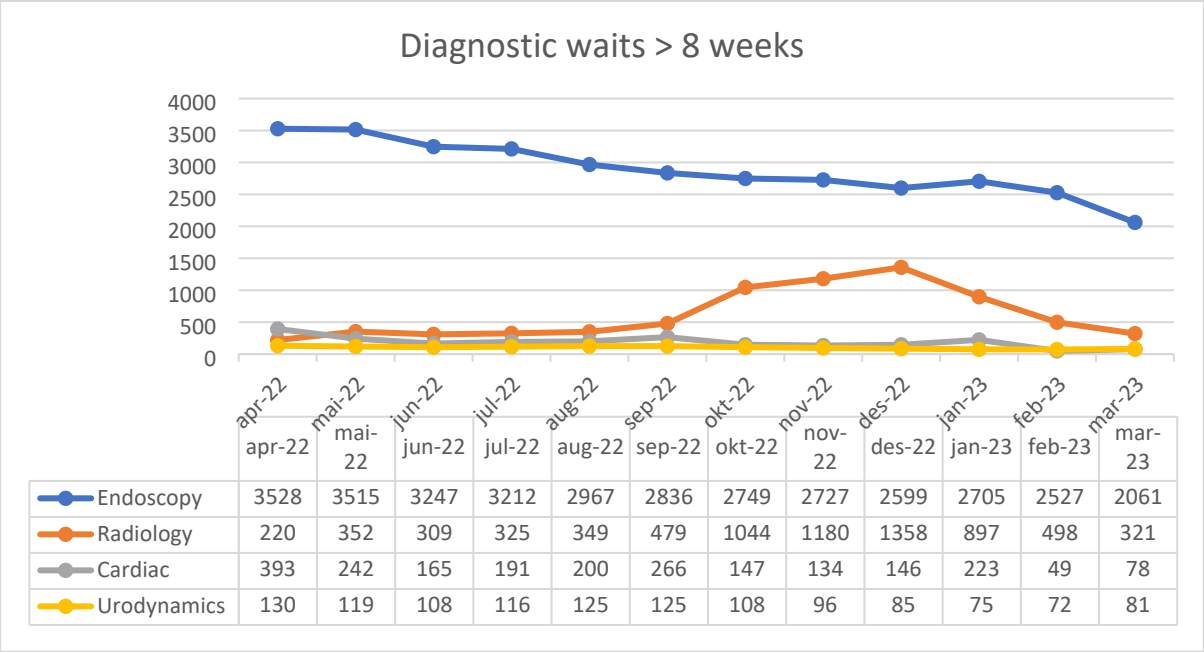
	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-23 - profile	9,300	290	17,940	12,884	2,573	0	7,220
Mar-23 - actual	9,552	12,090	9,799	14,017	3,715	1	3,751

Improvement in **outpatient performance** remains essential is a core focus of the Planned Care Programme. Despite tracking just above the trajectory, Aneurin Bevan has one of the smallest proportion of patients waiting more than 52 weeks for a new outpatient appointment.

Progress has been made with the new **See on Symptom** (SoS) system. A '**Patient initiated follow-up'** (Pifu) Implementation Plan with **12 new pathways** developed. The Health Board has also worked hard to increase treatment capacity post COVID and following the opening of the Outpatient Treatment Unit at the Royal Gwent Hospital, capacity is currently 105% of pre COVID levels. The outpatient treatment unit has two treatment rooms and whilst the first is fully staffed, a plan has been developed and is in place to staff the second room.

Access to timely and effective **diagnostics** is critical in providing high quality care, reducing waiting times for treatment and improving health outcomes. As seen in the graph below cardiology has seen significant

improvement, driven by use of an insourcing company to deliver additional echo capacity.

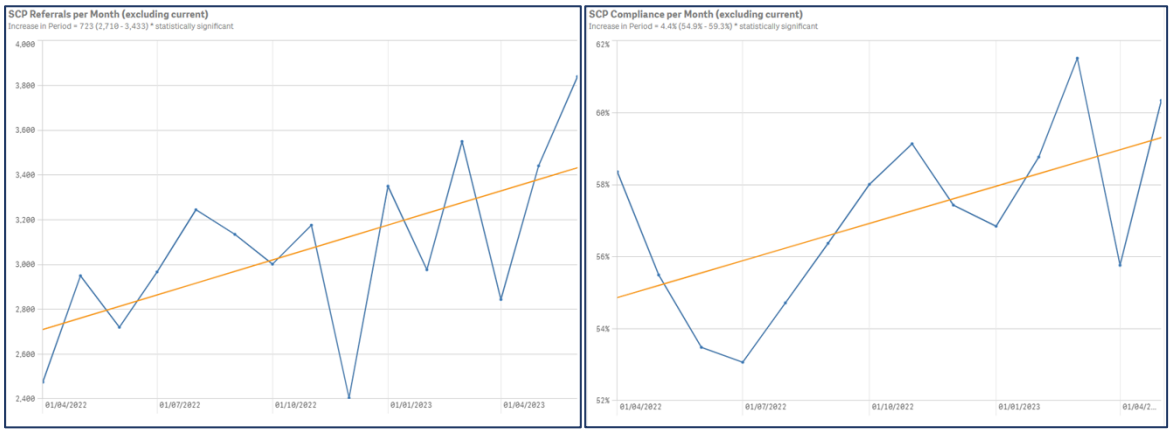


	apr-22	mai-22	jun-22	jul-22	aug-22	sep-22	okt-22	nov-22	des-22	jan-23	feb-23	mar-23
Endoscopy	3528	3515	3247	3212	2967	2836	2749	2727	2599	2705	2527	2061
Radiology	220	352	309	325	349	479	1044	1180	1358	897	498	321
Cardiac	393	242	165	191	200	266	147	134	146	223	49	78
Urodynamics	130	119	108	116	125	125	108	96	85	75	72	81

Further key areas in diagnostics include:

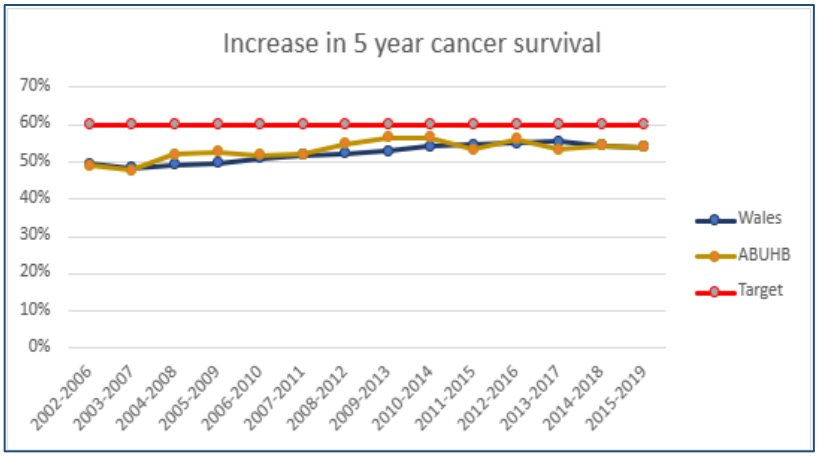
- Continued insourcing of additional endoscopy capacity has supported a maintenance in the 8-week backlog with a small decrease in the numbers of people waiting at the end of March (2,061).
- Radiology diagnostics waiting times have reduced during Quarter 4.
- The future developments of the RGH endoscopy unit has progressed with approval to recruit ahead of the new unit opening in 2023. It should be noted that this is to sustain services and is predicated on the backlog being cleared by the point of opening of the new unit.

Compliance against the **Suspected Cancer Pathway** (SCP) has increased from 55.6% (November 2022) to 58% at the end of March 2023. Whilst performance is compliant with the planned care recovery level of 55%, this remains lower than the national target. Significant increases in demand relating to suspected cancer referrals have continued to exceed 2,500 referrals per month and is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres.



There are a number of factors which have had an impact on overall performance. A primary driver is a considerable reduction in skin treatments. The volumes for this specialty have historically contributed in increasing the performance denominator. This reduction has been influenced by the capacity challenges faced by histopathology and an action plan is in place to improve the position through outsourcing. The capacity to deliver the diagnostic component of the pathway is a significant constraint to delivering the SCP.

Overall, there has been significant improvement in the rate of 5-year cancer survival reported over the last 10 years.



A similar score was reported for the mental health well-being of adults in the Health Board, although a small increase has been observed from 50.3% to 50.5% in 2018/19, contributing to the progress towards the achievement of the improved mental health resilience in adults outcome.

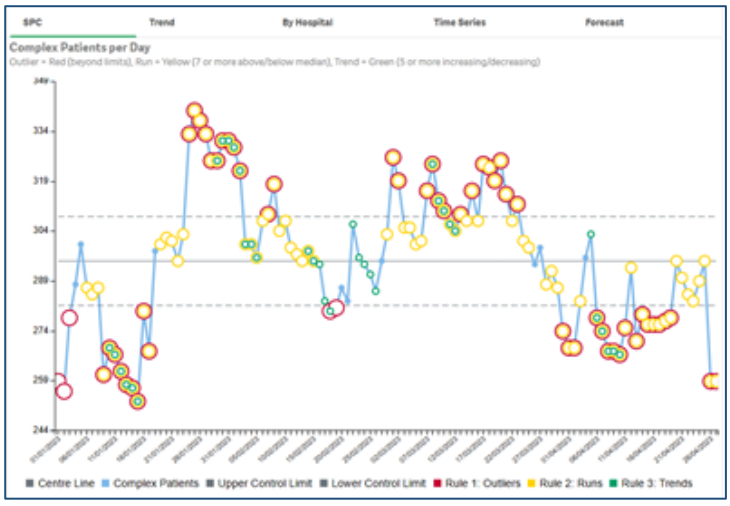
Priority 4

Older adults are supported to live well and independently

Supporting **older adults** to live well and independently is a core component of the Health Boards' plan for a sustainable health and care system. We know we need to deliver improvement for this population in our service offer. Redesigning services for older people is a Clinical Futures priority programme. We seek to deliver three outcomes, and an overview of our progress in 2022/23 is shown in the table below.

Our Commitments	Our Measures	Our Performance
Prevention and keeping older adults well 	Increase in older people in good health	Indicator being developed as part of Marmot work
Delivering care closer to home 	Increase in Rapid Response within 4 hours	Similar(38%)
	Reduction in the number of short stay patients (<7 days)	Similar (12%)
	Reduction in average LOS case load	Deteriorated (52.7 days against 40-day baseline)
Reducing admissions and time spent in hospital 	Increase in Admission avoidance (month)	Improved (across 4 Local Authority Areas)
	Decrease in number of patients whose LOS is over 21 days	Improved (65% (134/206) to 56% (145/264))

The 'Delivering Care Closer to Home' outcome has seen a deterioration in 1 indicator values; however, a Cyber incident in August 2022 has impacted the system that captures and hosts the data therefore it is not possible to provide a Quarter 4 update for 3 of the metrics. At the end of Quarter 1, rapid response within 4 hours had decreased across all 4 reported Borough areas (data excludes Monmouthshire) from 38% to 35%. There was also an increase reported in the average length of stay of people. This is most notable in Blaenau Gwent and Newport Boroughs. The 'reduction in the number of short stay patients' indicator value has been sustained at around 12%.



This is an area of focus for the next financial year, in partnership with the Integrated Service Partnership Board and Regional Partnership Board structures, to support the care home sector, enhance our Rapid Response Model, and access to hot clinics, providing single points of access and direct admissions pathways.

Priority 5

Dying well as part of life

The IMTP sets out our commitment to improve continuously what we do to meet the need of people of all ages who are at the end of life. The measures represent indicators to support the organisations understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care. We seek to deliver two outcomes, and an overview of our progress in 2022/23 is shown in the table below.

Our Commitments	Our Measures	Our Performance
Improved end of life care experience 	Decrease in the % of hospital as a place of death	Improved (50%)
	Increase in compliance of issuing of Medical Certificates within 5 days	Improved (83% within 5 days)
	Reduction in complaints	Indicator being developed
Improved planning and provision of end of life care 	Increase in proportion of Urgent Palliative Care referrals assessed within 2 days	Improved (91 to 99%
	Increase in the number of Advanced Care Plans in place	Indicator being developed

For the 'Improved planning and provision of end-of-life care' outcome, there has been a significant increase in the proportion of Urgent Palliative Care referrals assessed within 2 days since July 2020 and a further increase from 97% to 99% during Quarter 2 and Quarter 3.

Further outcome measures and indicators are still being developed nationally and this priority will evolve to incorporate the relevant outcomes.

5. Integrated Medium Term Plan 2022/23 – Priority Programmes

Our organisational priority areas of work are designed to create and optimise the right capacity to meet the needs of our population through service development, redesign and/or transformation and to positively impact on population health and achieve improvement across the life course of an individual. These programmes are underpinned by a relentless focus on quality and safety.

By their very nature, these key strategy priority programmes are complex, system wide and will be delivered over the life of the 3-year IMTP and beyond. This section provides an overview on progress that has been delivered during 2022/23.

Prior to the pandemic, the situation in Emergency Departments was increasingly difficult, with demand soaring and the percentage of people being seen within the four-hour target reaching an all-time low over the 2019/20 winter. Since lockdown eased, demand has steadily risen, and a greater number of people with serious problems are presenting themselves in our urgent and emergency care system.

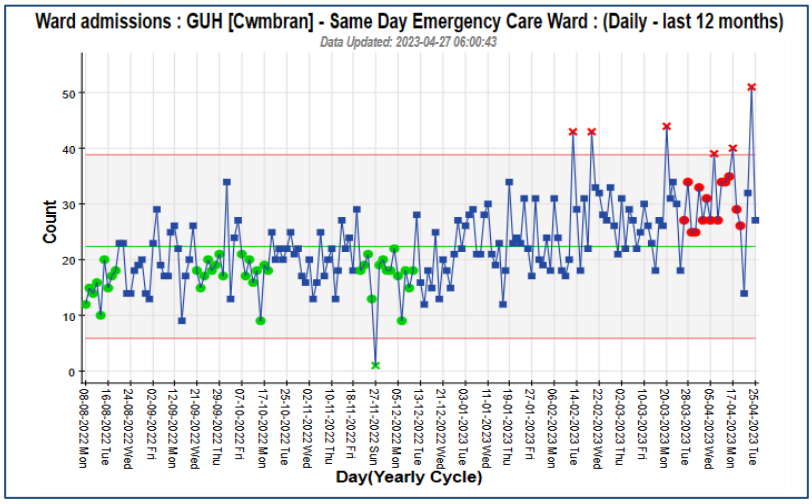
Urgent and Emergency Care Improvement

(6 Goals)

Welsh Government published a handbook to assist Health Boards to **improve urgent and emergency care** focusing on strengthening signposting, clinically safe alternatives to admission, rapid emergency care response, good discharge practice and preventing readmission. During 2022/23, we have seen broadly positive momentum through each of the goals in the context of significant operational pressure.

Some areas of progress include:

- A 'high intensity user service model' exists, where referrals are made to a Lead Nurse who is able to make the right social referral required to support the patient in safe discharge.
- Following the opening of Same Day Emergency Care (SDEC) at Ysbyty Ystrad Fawr non recurrent funding has now been secured.



- The establishment of SDEC is an important addition to our emergency care services and provides significant opportunities to stream patients from same day to next day and act as a catalyst for speciality ambulatory service development. Since the opening of SDEC at the Grange University Hospital, 4,054 patients have been seen (average 20-25 daily attendances) all discharged the same day with a median length of stay time of 3.6 hours. Since the opening of SDEC at YYF, 678 patients have been seen.
- Urgent Primary Care continues to be strengthened and receive referrals from re-directions, 111 and in-hours primary care escalation.
- We have received funding via the Six Goals national 'Innovation Fund' to support implementation of an electronic Triage solution for ED in order to improve clinical visibility and improve patient experience.
- Elderly Frailty Assessment pilot has now been completed at GUH with a number of positive learnings and actions for follow-up.

- Ambulance handover improvement is a key focus for the programme and there are plans to pilot a push model of flow to encourage timely referrals of patients to specialities at given times of the day.
- A business case has been approved to provide additional Front Door Therapies staff dedicated to ED to support a 'home first' approach.
- An Integrated Discharge Board has been established with engagement from Local Authority partners, Welsh Ambulance and medicine, nursing and therapy colleagues.
- Good progress has been made with the Royal Gwent Hospital Discharge Hub pilot with health and social care teams now integrated and co-located.
- The Nevill Hall Hospital Pull Model has already provided improved communication with multi-disciplinary teams, which is evidenced in an increase in timely discharges and positive patient feedback.

Risks and Further Development Areas

- As set out in the performance information, developing urgent care services is being delivered in parallel with responding to significant pressure. Much of the development of this programme has supported responding to the pressures rather than fundamental service change
- Goals 5 and 6 of the programme focus on discharge to home, further progress is needed in this area which can only be achieved through partnership.
- Areas of focus for the programme include greater development of SDEC medical services, further preventative and redirection service and a prioritisation of discharge

The **Enhanced Local General Hospital** (eLGH) network was made possible when the Grange University Hospital opened in November 2020. The roles of the Royal Gwent (RGH) and Nevill Hall (NHH) Hospitals changed to be more similar to Ysbyty Ystrad Fawr (YYF). The eLGH model provides local emergency care services, outpatients and diagnostics, planned care day case and inpatient and/or daycase surgery and medical inpatient beds on all 3 sites. They hold key roles in providing direct emergency care and supporting patients who have received emergency and inpatient care at the GUH but who are not yet ready for discharge due to ongoing care needs including rehabilitation. In addition, each eLGH is developing specialist Health Board wide or regional services roles, for example the Breast Care Unit at YYF and the proposed developments of local cancer and radiotherapy services at NHH.

This workstream is focused on optimising the design of the hospital network across the Health Board, focusing on the clinical models. In addition, the remit has been expanded to consider the future acute medical model for

the eLGH sites and options for the long term sustainability of service delivery.

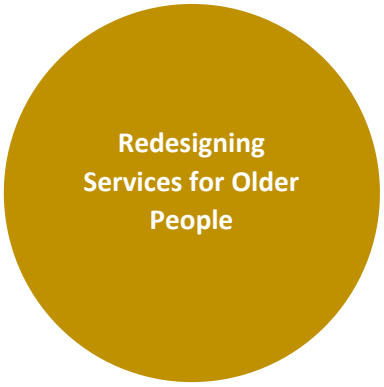
Some areas of progress include:

- Completed reconfiguration of ward A1 at the Grange University Hospital to optimise patient flow through Emergency Department, Surgical Assessment and Acute Medical Unit
- A review of Stroke services by the national Getting it Right First Time team has been undertaken, along with scenario modelling for reconfiguration of stroke services, to address stroke sustainability issues. Early 2023/24 will see the mapping of workforce elements across medical, nursing and therapies.
- Building works began on the Breast Unit at Ysbyty Ystrad Fawr, this unit will offer a wide range of services, tailored to meet the specific needs of patients. It will focus on timely, effective access to treatment, ensuring person centred care is at the forefront when delivering our breast care services.
- Works have commenced in readiness of building the Satellite Radiotherapy Centre at Nevill Hall Hospital. It is anticipated this unit will open Autumn 2024.
- Evaluation of the 'Homeward Bound Wards' reviewing the support to those who are medically optimised to discharge has been completed.
- Establishment of Acute Medicine workstream to review workforce and patient flows since the opening of the GUH and to create a sustainable eLGH acute medicine model.
- Stabilisation of junior medical staffing for the acute medicine model with collaboration from HEIW.

Risks and Further Development Areas

- The most significant risk to optimising our ELGH model is availability of sufficient workforce. National and local shortages in specialist areas means it is not possible to enable all parts of our model.
- Therefore the focus for the next period will be considering clinical models in context of workforce and pathway developments

The importance of improving care and support for **older people** has been reinforced through our dynamic planning approach. It shows, in the starkest of terms, the cost to our system because the offer to older people falls short of what is needed to support them to live well and independently. The system needs further transformation urgently to ensure that older people can access evidence based clinical interventions that respond to their needs, in the context of what



matters to them by ensuring that the care they receive helps prevent dependency now and later in life.

Some areas of Progress include:

- Early intervention workstream was supported by three workforce sustainability and transformation winter bids which included additional Community Resource Team staff to bolster out of hospital care and prevent avoidable hospital admissions and expedite discharge, increased Urgent Responsive Care (Emergency Care at Home); and focus on supporting the Proactive Frailty (HRAC) cohort who we know are high users of our hospital system. This is to support system safety over the winter and test intervention to support capacity gaps.
- Engagement events have commenced with key stakeholders and staff to inform the optimal care pathway and describe the future model of care for older people.
- The mapping of resources to target limited resources in the right area has begun supported by the Value Based Health Care team. A proposed model for ambulatory care has now been developed and an audit is planned to ascertain patient needs and numbers of people who could access this pathway.
- Assessment of unmet need has been progressed to inform plans for further 'Hot Clinics'.
- Work is progressing to develop an Emergency Care at Home model to support people at home, including out of hours, across all areas and to recruit overnight HCSWs.

Risks and Further Development Areas

System pressure has impacted progress in this programme with high occupancy in community hospitals and wider facilities limiting ability to drive transformation

The programme has identified key interdependencies with the six goals programme therefore greater alignment will be a focus in the next period

The **Primary Care Model** for Wales sets out how primary and community health services will work within the whole public sector system to deliver **Place-Based Care**. Collaborative work is at the core of this bringing together local health and care services to ensure care is better coordinated to provide care closest to home and promote the wellbeing of people and communities. We have a core programme team which includes the Clinical Director for Primary Care, Workforce, Finance, Planning and Clinical Futures Programme support to develop a local

programme plan to deliver a regional response to the nationally set ministerial milestones. The focus to date has been to undertake core briefing and engagement work to establish the professional collaboratives, and a Neighbourhood Care Network (NCN) office to enhance support for front line staff in planning and delivering for their local population, and undertake the readiness assessment exercise and closing the required actions.

Some areas of progress include:

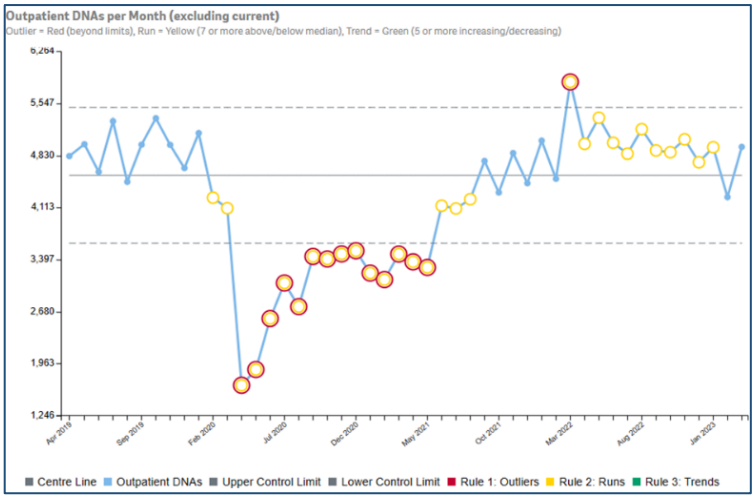
- Alignment of the work of our NCN plans, pan-Cluster Plans (ISPB plans) and the Regional Partnership Board Area Plan.
- Good progress within the communication and engagement strategy including the 'Be Kind' campaign roll out across social media and independent contractors, receiving positive feedback. Additional NCN branding has been developed along with a website and newsletter featuring GP Practice role videos
- Following the establishment of NCN Office, organisation development and sustainability has been a key priority with development sessions planned and delivered for NCNs and professional collaboratives.
- NCN and draft ISPB plans submitted to the Regional Partnership Board
- Engagement with partners in developing an NCN Business cycle.
- Population needs based planning framework developed and socialised.
- Engagement with RPB and Integrated Service Partnership Boards regarding the latter adopting the function of the Pan-Cluster-Planning Groups.
- NCN office supported NCNs in delivery of their plans including supporting evaluating and scaling up projects.
- Professional Collaboratives were established and have begun to respond to published population needs assessments and to identify their service gaps.

Risks and Further Development Areas

- The programme has focussed on establishing the governance foundations for integrated working at a NCN level, the next phase is to move to defining actions and delivery programmes focussed against needs assessments
- creating headspace and time for busy primary care professionals is a key risk area for this programme as well as sufficient workforce with shortage professions such as general practice

In April 2022, Welsh Government published the 'Transforming and modernising **planned care** and reducing waiting lists' plan to encourage a focus on key areas. These are: transforming outpatient services; prioritising diagnostic services; early diagnosis and treatment of suspected cancer patients; patient prioritisation to minimise health inequalities; very long waiters; building sustainable planned care capacity; and improving communication and support. These national objectives are in line with those identified in our IMTP and continue to endorse our focus on these key areas of recovery. An update on performance measures can be found within the outcomes and performance summary.

Some areas of progress include:



- Collaborative working between clinicians and Value-Based Health Care team to prioritise initial health care pathways for localisation based on national and local priorities. During the last quarter, a business case was agreed and funding for health pathways has been allocated.
- ABB Waiting Well website has been launched to support patients to keep well before surgery or planned treatments to help give patients the best chance as possible as well as supporting recovery.
- The outpatient transformation programme continues to develop and roll response plans including 'See on Symptoms' and 'Patient Initiated Follow Ups'. Implementation of outpatients DNA Plan (currently 6.5% against a 5% target) and Hospital Cancellation Plan (currently 18,950 compared to 40,952 in 21/22).
- A Diagnostics Board has now been established with a direct link into the national and regional planning. A National and regional diagnostic plan is due to developed from Quarter 1 23/24 with a local solution to be approved.
- A time and motion study was undertaken and a theatres stakeholder event took place, detailing improvements being rolled out across teams.
- The Planned Care Academy concept was detailed to the Delivery Unit, receiving a positive response and offer of support secured. The model will be refined during the next quarter with a plan to roll out during the next financial year.

Risks and Further Development Areas

- The impact of system pressures has affected planned care performance and development with the compromising of bed spaces and the need to move staff to support urgent and emergency care
- The balancing of financial pressure and tackling long waiting lists also remains a risk area.

Cancer outcomes need to be improved. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected of having cancer. The Cancer Strategy, 'Delivering a Vision 2020-2025' sets out the broader context with prevention, early detection, patient experience, living and dying with cancer, cancer research and access to novel therapies are also key components of the approach to transforming cancer services for our population.

Whilst it is too early to be able to measure the impact of successive pandemic waves on morbidity and mortality for cancers, there is concern that a reluctance by patients to attend primary care and hospital, together with the temporary suspension of national screening programmes and longer waiting times for diagnostic tests and treatment will result in patients presenting at a later stage in their cancers which will make improving cancer outcomes more challenging. Planned Care and Cancer Services are inextricably interconnected; it is the same workforce, accessing the same diagnostic and treatment capacity.

Some areas of progress include:

- Significant progress has been made in establishing the Transforming Cancer Services Programme and identifying and distinguishing areas of work and activity
- Continued focus on delivery against the 62 day pathway, and ministerial challenge to achieve 70%. Improved 62.5% adherence to Single Cancer Pathway in March 2023.
- Reporting arrangements for Histopathology outsourcing have been agreed. The newly form Diagnostics Board receives assurance on delivery against trajectories and plans will receive escalations, apart from those areas that impact on Cancer.
- Patient Navigator for Endoscopy has resulted in a notable improvement in days of first contact from 68.8% in January to 85.5% in April.
- Demand and capacity dashboard have been created and have now been rolled out to all specialities with the aim to embed within day-to-day management.

- At the beginning of Quarter 4, Welsh Government announced a £38 million investment to improve cancer radiotherapy services with a new radiotherapy 'Satellite' centre at Nevill Hall hospital, which will be open by 2024.

Risks and Further Development areas

- Significant backlogs and increases in referrals have challenged progress in programme delivery
- As with other programmes key workforce challenges in particular tumour sites has slowed progress and required consideration of revised models of care

COVID-19 has shone a spotlight on the inadequate level of preparedness for the challenges faced by our population, our workforce, and our services. The level of ambition for **Public Health Protection** including preparedness for managing infectious outbreaks, contact tracing, protecting most vulnerable populations and workforce, effective surveillance and higher vaccination uptake must be stronger.

As a population health organisation **reducing health inequality and improving health** is at the core of everything we do. Our long-term ambition to reduce demand for healthcare is fundamental to a sustainable system of care. This can only be achieved through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimal treatment of disease.

Some areas of progress include:

- Covid-19 spring booster commenced April 2023. Vaccinations to 25th April: 2,219 care home residents, 1,350 house bound, 5,789 over 80s, 4,142 Monmouthshire residences via GPs and community pharmacy.
- Multi agency steering group has been established to focus on the Hep B and C Elimination programme with a key priority to explore an outreach model.
- A review has been initiated of the post-arrival pathway for asylum seeking initial TB screening and Blood Bourne Viruses (BBVs).
- Significant progress has been made towards a full implementation of Health Protection Services transition with the redesign of services and structures beginning to be populated. The testing function transitioned to Public Health in April.
- Integrated Health Protection Service Business case development is on track and scheduled for the Pre-investment panel during Quarter 2.

- Continued Monkeypox vaccine clinic organisation and delivery with the embedding of the Monkeypox vaccination as business as usual.
- Support Hepatitis B and C elimination plan through reviewing action plan and population level data review.

Risks and Further Development Areas

Developing from a responsive to proactive health protection service has been challenging due to the requirements of responding to the pandemic and other public health outbreaks.

Focus in the next period will be on shifting to a proactive model of prevention services.

Our vision is to provide high quality, compassionate, person-centred **mental health and learning disabilities services**, striving for excellent outcomes for the people of Gwent. There are 2 transformational Programmes (Whole System, Whole Person Crisis Support Transformation and Complex Needs) that will deliver this vision. There are multiple projects that sit under both Programmes including:

▪ 111 Press 2 for mental health ▪ Primary Care Mental Health Service ▪ Redesign of inpatient care (service model, configuration, workforce and estate) ▪ Complex needs pathway ▪ Strengthening crisis assessment and home treatment services ▪ Improving transport for patients in crisis ▪

Through a single point of access, we are developing a variety of sanctuary services (in Emergency Department and community), shared lives scheme, acute inpatient provision, housing tenancy and support, mental health support for first aiders, crisis assessment, home treatment and liaison, and Support House.

Some areas of progress include:

- Mental Health 111 has launched and is embedded as a 24/7 service
- Since the implementation of the Adult Mental Health Shared Lives scheme, a total of 166 placements have taken place, with an average length of stay of 14 days, 49 of which were as an alternative to hospital admissions. Some key benefits of the scheme realised include delivering care closer to home across all 5 boroughs; improved efficiency and effectiveness across the system with service users, as appropriate, provided an alternative to a ward stay; reduction in onward referrals into traditional inpatients settings or acute interventions; improved person-centred outcomes and excellent host/carer experience. The

scheme has won and been nominated for a number of awards including 'Scheme Innovation Award' at the Shared Lives Plus 2022 awards. Additionally, a paper by Dr Benna Waites, Consultant Clinical Psychologist, has been published by the World Health Organisation.

- Outline Business Case for 65 bedded Mental Health Speciality Inpatient Services Unit has been agreed by the Health Board and has been submitted to Welsh Government for approval. Next steps include preparing for a public consultation for the SISU location.
- Since the opening of Ty Cannol Crisis/Support House at the end of 2021/22, 90% of the patients that have been admitted onto Ty Cannol have prevented them from being admitted into the wards.
- Improvements in eating disorder services supporting early identification and treatment to optimise outcomes.
- Older Adult (OPAL) and our Primary Care Learning Disability Liaison Services are recognised as Welsh Exemplars.
- Implemented changes to models of delivering psychological therapies to improve access and patient choice.
- Peer mentors, peer supported open dialogue and road to staff wellbeing
- Continuation of Emergency Department sanctuary service.

Risks and Further Areas of Development

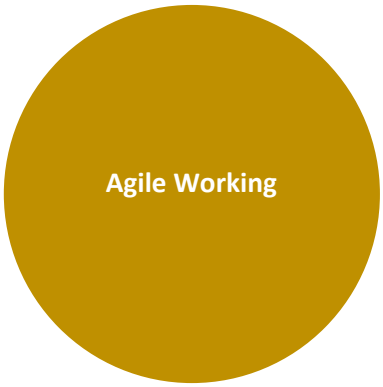
- There remains significant pressure on services in meeting the emotional and wellbeing demand created by the pandemic
- Greater focus on the next period will be on working through partnership to establish robust tier 1 services with and for communities

Welsh Government declared a Climate Emergency in 2019 and set out their ambition that the public sector in Wales should be in a carbon '**Net Zero'** position by 2030. The response to the pandemic had demonstrated how significant and impactful changes can be incorporated into day-to-day life of the public and the approach to work for example remote working. Our ambition, now, is for a sustainable and healthy recovery with concerted actions within and across our system to tackle the climate emergency.

Some areas of progress include:

- The Health Boards carbon emissions are tracking -3.1% at year end.
- All biodiversity reports have been received and are being reviewed to incorporate into plans, along with a review of net zero data.
- Work is progressing with the communications, digital and training workstream, with digital representation being identified.
- Endoscopy is currently reviewing and researching into the use of alternatives to Entonox for sedation/ analgesia.

- Roll out of Electric Vehicle Charging points has been completed and additional charging points for RGH as part of a new capital bid have been provided.
- Progression of the outcomes of the solar panel report looking at roof space alternatives for solar panel systems.
- Pharmacy and Respiratory services are reviewing opportunities for decarbonisation in the use and provision of inhalers.
- A metrics format has been updated and available data has been prepared and shared with the board. This will be refined further to support reporting for the Welsh Government Carbon return later this year.



Welsh Government has developed an approach to **agile working** following the need to work differently through the recent Covid 19 Pandemic, based on service needs, providing a variety of options for employees on where, and how they want to work. It means offering mixed-use spaces with a variety of services, workspaces, and environments. More modern agile workspaces are not just about working from home, hot desking and sharing office space, but changing the cultural mind-set and ensuring working environments support break-out spaces to encourage communication, providing areas for impromptu meetings and collaborative work.

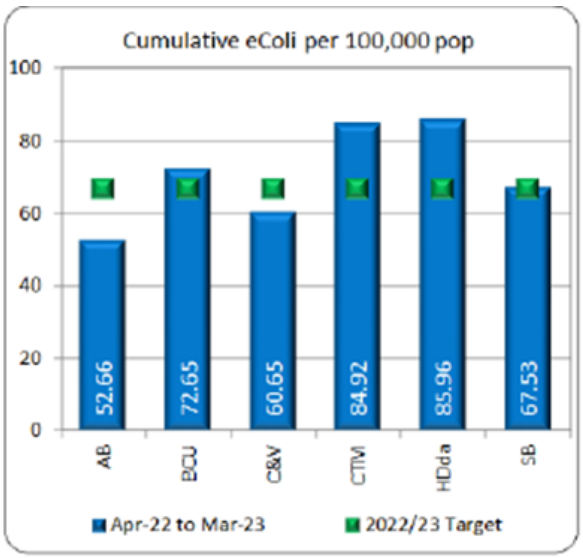
Some areas of progress include:

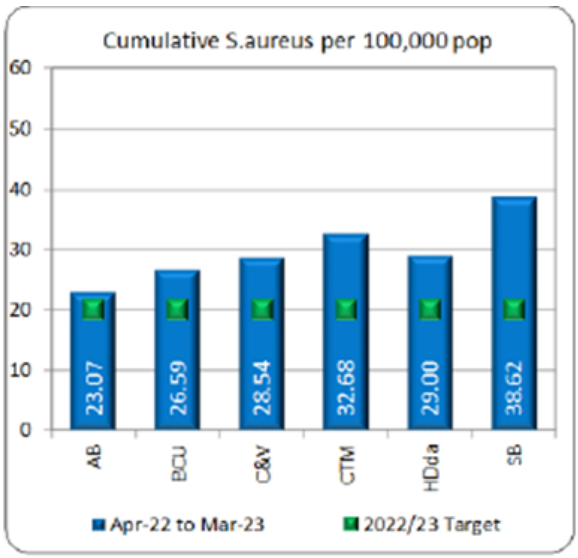
- Delivery plan to support the roll out of the Agile Framework has been developed.
- Mapping of staff at St Woolos has been completed to support the assessment of re-accommodation of existing requirements on the RGH site and other sites. Assessment is due to be validated during the next quarter.
- Revised vision for agile working presented to the Executive Team and further updates provided to the Agile Programme Board in April.
- Engagement with all 5 local authorities to scope out joint working options. An agreement has been sought to set up a network with local authority and health to share good practice and look at estate opportunities jointly.
- Engagement with staff to promote agile/hybrid working principles via engagement with Divisions and retention cafes.
- Additional space at Caerleon House with 8 agile spaces created within the open plan area and an additional 3 meeting rooms that can also be utilised.

6. Integrated Medium Term Plan 2022/23 – Quality and Safety

Quality and safety are at the centre of our work to secure improvements in the quality of care and services we deliver and to improve outcomes for the population we serve. The Board has approved its Quality Strategy, confirming the quality pillars. These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

- Urgent Care remains one of the top organisational risks, an issue mirrored nationally, with the Emergency Department at the Grange University Hospital seeing an increasing trend in the number of attendances. The Health Board is committed to delivering safe and effective care to the population of Gwent and in order to be able to identify the level of risk within the department, a clear focus has been placed on triage which will have an impact on the time for a patient to be seen by a clinician. Knowing the triage category of patients helps to manage the risk for individuals. Whilst the target of <15minutes for triage has not yet been met, the Health Board has been operating either in-line or below forecasted levels. A focus has been on addressing the increasing trend in ambulance handover times and a review of criteria, which enable patients to be moved from an ambulance to sit within the department has been undertaken. In addition, a Standard Operating Process (SOP) has been developed which references the actions required when there are off-loading delays for patients, and in particular, to ensure the release of red requests.
- There were on average 469 patients per month waiting in ED over 16 hours during quarter 4, which is a reduction from 674 reported during Quarter 3. Time from request to bed allocation has also reduced from 13.6 hours to 10.4 hours. Quality metrics are regularly monitored by the Senior Management Team (SMT), the Divisional Management Team (DMT) and escalated accordingly. Patient falls, medication incidents and violence and aggression incidents are reducing.
- The Health Board has the lowest rates of eColi, S.aureus and Aeruginosa per 100,000 population across Wales. Whilst the 22/23 target rates of C.difficile have not yet been met, there has been a reduction in rates from 33.77 (Quarter 2) to 32.26 (Quarter 3) per 100,000 population.


Cumulative eColi per 100,000 pop
100
80
60
40
20
0
52.66
72.65
60.65
84.92
85.96
67.53
AB
BCU
C&V
CTM
HDda
SB
Apr-22 to Mar-23
2022/23 Target


Cumulative S.aureus per 100,000 pop
60
50
40
30
20
10
0
23.07
26.59
28.54
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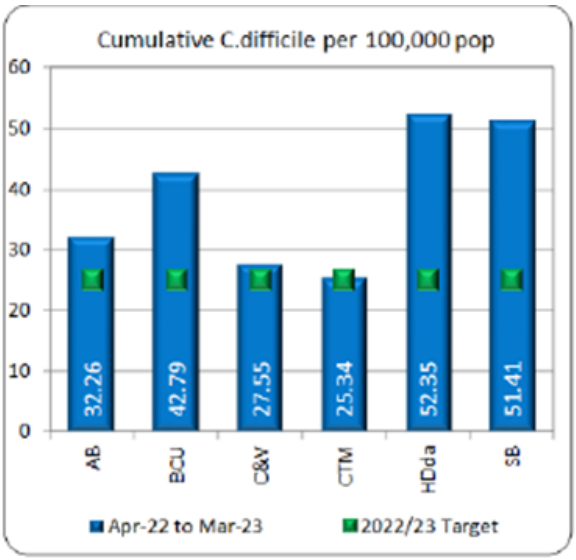
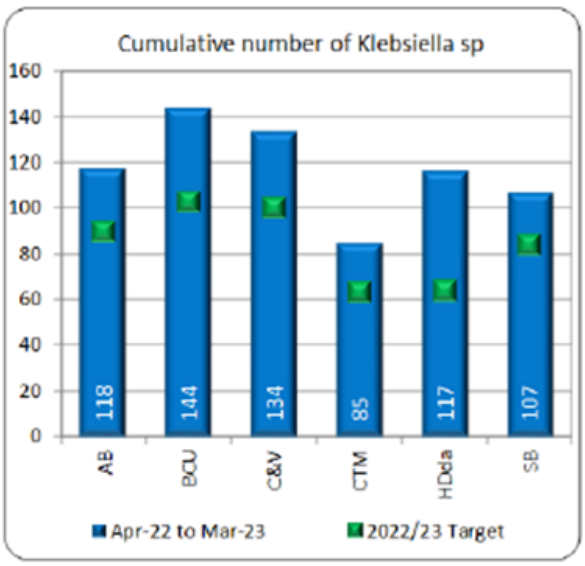
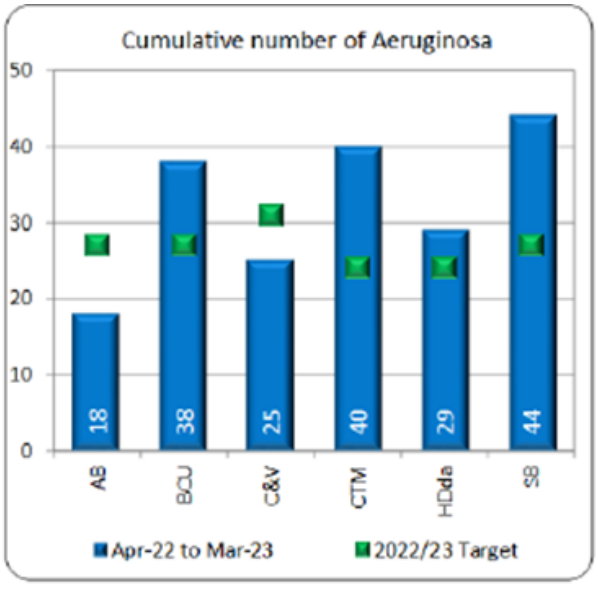
29.00
38.62
AB
BCU
C&V
CTM
HDda
SB
Apr-22 to Mar-23
2022/23 Target

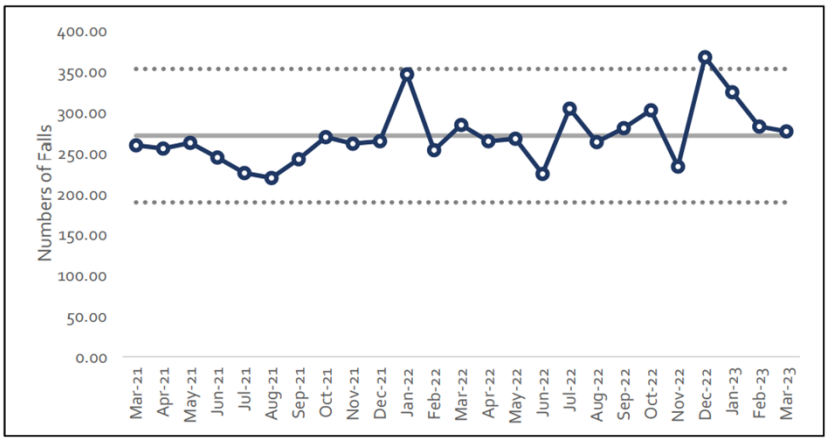

Cumulative C.difficile per 100,000 pop
60
50
40
30
20
10
0
32.26
42.79
27.55
25.34
52.35
51.41
AB
BCU
C&V
CTM
HDda
SB
Apr-22 to Mar-23
2022/23 Target


Cumulative number of Klebsiella sp
160
140
120
100
80
60
40
20
0
118
144
134
85
117
107
AB
BCU
C&V
CTM
HDda
SB
Apr-22 to Mar-23
2022/23 Target


Cumulative number of Aeruginosa
50
40
30
20
10
0
18
38
25
40
29
44
AB
BCU
C&V
CTM
HDda
SB
Apr-22 to Mar-23
2022/23 Target

Falls

Analysis of data associated with Inpatient (IP) falls management continues to be monitored over a two-year rolling period to provide assurance. This approach identifies any changing trajectories or statistical variation in the numbers of falls incidents. The mean average number of monthly falls has been maintained circa 270 per month. For the year 2022/23, incident reporting numbers have been subject to a greater degree of variation as compared to 2021/22, with December 2022 being marginally above the upper control limit. Quarter 4 has seen a return to a downward trend with values for February and March being more closely aligned to the mean average. 91% of the fall's incidents reported are categorised as no or minimal harm.



7. Putting Things Right

Patient experience and listening and learning from feedback is a key element of evaluating services and outcomes and a measure of the impact of how we are performing. One way of evaluating patient experience is via complaints data.

Throughout 2022–2023, Aneurin Bevan University Health Board complied with the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011 regarding the Putting Things Right process.

The Health Board received 3044 complaints in the financial year 2022-23 (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations relating to cross border services). This is a 9% decrease when compared with 2021/22, when 3,295 complaints were received.

- 1,484 complaints were classified as Managed through PTR (formal complaints).

- 1,560 were managed under the Early Resolution process.

Of the 1,117,572 patient interactions that took place in the 5 largest divisions (admissions and outpatients) the 3044 complaints raised equate to a 0.27%.

The top three themes raised during this period were:
1. Clinical treatment/assessment
2. Appointments
3. Communication/Information

Clinical Treatment/Assessment
Waiting times remain a key concern for patients both for planned and unplanned care. The pandemic impact on waiting lists is a key concern for those waiting, along with the challenges in accessing urgent care for Covid and non-Covid reasons.

The establishment of a formal Planned Care recovery oversight Programme continues to focus upon this issue and provide support for patients whilst awaiting surgery including optimising their health pre surgery. Regional plans for cataract surgery are being explored in order to optimise capacity, assets and resources across the region. A similar model is being adopted across diagnostic radiology.

The Urgent Care Board continues to focus on patient's assessments and ambulance waiting times.

Appointments
The Covid-19 pandemic recovery continues within the Health Board in order to reduce waiting times and cancellations for patients on waiting lists. This has intensified concerns related directly to delays to receiving an appointment and further delays to starting treatment plans. Throughout the reporting period, these remained consistent. There is an increased use of text communication/reminders to patients in addition to traditional paper letters.

Communication
A recurring theme of concerns resolved through 'early resolution' has highlighted that communication issues persist. This is reflected in 313 out of 392 complaints related to communication being dealt with under Early resolution. The main themes of these complaints relate to frustrations from families being kept up-to-date regarding their relatives care at ward level and their subsequent discharge, and an increase attributed to the long waits in A & E. Capacity of staff has meant that often they are unable to consistently update the person on their progress through their pathway on presentation to the department and relatives who are waiting to hear the admission/treatment plan.

The Health Board has continued with the previously piloted Patient Liaison Officer Service to support Health Board Communication. This service runs from 8am-8pm, 7 days a week at the 3 acute sites, linking in with the other hospitals, acting as a link between the caller and the wards. Relatives are encouraged to telephone the wards first and if no response to ring a dedicated telephone line.

There is a proposal that the Health Board that in order to formalise the success of the PLO service to implement that a new service the Patient Advice and Liaison Service (PALS) will be launched. This will offer confidential advice, support and information on health-related matters. This service that will be a visual on-site presence for patients and families to access to further support to address urgent issues that can be resolved informally and at source.

Following ABUHB being identified as a pilot site for 'SignLive', last year, the service for the Health Boards BSL deaf community is now operational on all hospital sites. Patients can access BSL services where an interpreter is not immediately available 24 hours a day/365 day of the year. This was introduced following increasing complaints about the lack of BSL provision, delays in interpreters being available for face-to-face consultations and appointments jeopardised as a result and has been positively received by patients.

Redress

The Health Board has a well-established Redress Panel to make these determinations, meeting monthly to ensure cases heard timely. This is a high-level panel with quorate membership for Medical, Nursing and Therapies Executives or nominees, together with the Chair. In addition to determinations of qualifying liability, there is a strong emphasis on ensuring that learning and actions have taken place to try to prevent future patient harm. Areas of good practice are also highlighted and shared.

It is nationally recognised that the Redress aspect of the all-Wales 'Putting Things Right Regulations' has provided a much-needed alternative to formal legal proceedings for patients and their families, achieving resolution within much shorter timeframes, and cost savings of legal proceedings.

During 2022/23, the Redress Panel heard 68 cases. Whilst clinical treatment, including delays and diagnosis, were the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.

Public Services Ombudsman Wales (PSOW)
During 2022/23, the PSOW received 165 referrals. Of these, 33 were taken on as full investigations for the Heath Board and 35 cases were not considered for further investigation. The remaining 97 referrals were anonymous, requiring no action from the Health Board.

There has been an increase in complainants going to the PSOW who are experiencing significant delays in receiving a Health Board response to their original complaint. This is leading to PSOW recommendation for financial compensation or apology. The Health Board paid out £4550 in PSOW settlements in 2022/23.

Improving Safety - Learning from Serious Incidents
From 14th June 2021, the National Reporting Framework replaced the Welsh Government Serious Incident reporting criteria. The focus of incident reporting previously at a national level has been to examine in detail specific Serious Incidents as set out NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations), primarily through the use of Root Cause Analysis. The National Patient Safety Incident Reporting Policy (May 2021) (phase one) has brought about a number of key changes to national incident reporting. Phase Two is due for rollout in April 2023. This will focus on themes of learning.

A robust internal investigative process, in collaboration with external partners, is maintained across the Health Board, ensuring that actions and, more importantly, learning continues. An example of this is the initiation of a collaborative Health Board/WAST weekly panel that explores joint investigations, identifies the lead reporting and investigative organisations, and shares information to inform these.

In 2022/23, there were 34 new reportable incidents that were managed through the Serious Incident Process as Red 1 (Corporate-led) or Red 2 (Division-led) investigations.

Learning
A work programme has been developed for 2023/24 based on the issues identified in 2022/23. In July 2023, a PTR Annual Report will be published which will outline in detail the work undertaken over the past financial year, lessons learned and practice improvements made in the endeavour to optimise resources and the service delivered to the community served by the Health Board.

8. Well-Being of Future Generations

The Wellbeing of Future Generations (Wales) Act (2015) ('the Act') is about improving the social, economic, environmental and cultural wellbeing of Wales, while also reducing health inequalities through long term prevention and the delivery of sustainable, outcome focused services. The Act has seven wellbeing goals and tells organisations how to work more sustainably

together to meet their duties under the Act by following five ways of working.

During 2022/23, the Health Board has worked closely with partners to produce robust well-being and population needs assessments, as required under the Well-being of Future Generations Act and the Social Services and Well-being Act. The Gwent well-being assessment was published in May 2022 and assesses the state of economic, social, environmental and cultural well-being in the Gwent area. Copies of both the Gwent well-being assessment and population needs assessment are available here:
Gwent Well-being Assessment: http://www.gwentpsb.org/
Gwent Population Assessment: https://www.gwentrpb.wales/home

Following publication of the Gwent well-being assessment, the Health Board has worked closely with partners to turn the findings of the assessment into a plan for Gwent - the Gwent Public Services Board Well-being Plan. Using the five ways of working, partners have come together to develop a plan which will deliver ambitious and transformational changes that cannot be achieved by individual organisations alone. The plan will cover the five-year period 2023-28, and is based on two strategic objectives and five steps. These are:

Gwent Well-being Plan strategic objectives:
1. We want to create a fairer, more equitable and inclusive Gwent for all.
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations.

Gwent Well-being Plan steps:
1. Take action to reduce the cost-of-living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes.
3. Taking action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment.
4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

The plan is due to be published in June 2023. Following this, the Health Board will undertake a review of its existing well-being objectives to ensure wherever possible, they are consistent with the Gwent Well-being Plan. The Health Board's self-assessed progress against its existing ten Well-Being Objectives for 2022/23 financial year can be seen in the table below.

Our Well-Being Objectives	*Where we are now*
1 – Support every parent expecting a child and give every child in Gwent support to ensure the best start in life	Being More Adventurous
2 – Support adults and children in Gwent to live healthily and to age well, so that they can retain independence and enjoy a high quality of life into old age	Making Simple Changes
3 – Promote Mental Well-Being as a foundation for health, building personal and community resilience	Being More Adventurous
4 – Encourage involvement of people who use our services and those they support, in jointly owned decisions regarding their own health and care plans, and in wider service planning and evaluation, so that we, with our partners, deliver the outcomes that matter most to people	Making Simple Changes
5 – Ensure that we maximise the effective use of NHS resources in achieving planned outcomes for services and patients, by excellent communication, monitoring and tracking systems in all clinical areas	Owning Our Ambition
6 – Promote a diverse Workforce able to express their cultural heritage, with opportunities to learn and use Welsh in the workplace	Making Simple Changes
7 – Develop our staff to be the best that they can be with high levels of employee well-being and, as the largest employer in Gwent, promote NHS careers and provide volunteering and work experience opportunities	Being More Adventurous
8 – Reduce our negative environmental impact through a responsible capital building programme and a sustainable approach to the provision of building services including; carbon and waste management, undertaking procurement on a whole life cycle cost basis and support local souring, promoting sustainable and active travel, and advocating improvements in environmental health	Making Simple Changes
9 – Plan and secure sustainable and accessible healthcare services ranging from prevention through to treatment, rehabilitation and recovery that meet current and future needs and address health inequalities and differing levels of need across our communities	Owning Our Ambition
10 – Continue to integrate our actions with wider public, independent and voluntary sector partners with the aim of developing streamlined, whole system services for people who use our services and those they support.	Owning Our Ambition

The new ways of working set out in the Act have continued to be embedded in the Health Board during 2022/23. Through the regional partnership arrangements of the Regional Partnership Board, **integration** has been

demonstrated through joint approaches to health and social care delivery. The Health Board's communications team have undertaken a number of public **involvement** and engagement activities during 2022/23. Through work on the Well-being Plan and Area Plan, the Health Board has worked in partnership to establish a **long-term** vision for transformation in Gwent. Through 'Building a Fairer Gwent': the Gwent Marmot Programme the Health Board is working in partnership to deliver an approach to **prevention** embedded in the social determinants of health. Finally, the work of both Gwent Regional Partnership Board and Gwent Public Services Board demonstrate how the Health Board is working in **collaboration** to achieve gains for the population of Gwent that cannot be delivered by individual organisations alone. Further detail is contained within Gwent Regional Partnership Board and Gwent Public Services Board's websites.

9. Equality and Diversity

Equality, diversity, inclusion and human rights are embedded in all aspects of the Health Board through our Values and Behaviours Framework and the Governance Framework. Furthermore, implementation of Standard 2 of the Healthcare Standards for Wales, ensures that the Health Board embeds equality and human rights across the functions and delivery of services, recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

The Health Board ensures that strategic decisions we make are informed by the Health and Care Quality Standards and are required to report annually on progress against the Duty of Quality using indicators and measures, patient and staff experience and stories, clinical audit, and inspection reports. Departments and services are required to use quality-related information to review how well they are doing, this is supported by regular patient surveying, including the implementation of the Civica Experience Wales system to collect real-time feedback from users of our services.

The Health Board runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services and help assure us in our relation to public involvement. A Diverse Communities Health Forum was established by the Health Board in January 2020 to engage directly with seldom-heard voices in our communities.

The Health Board employs a comprehensive system of Equality Analysis, also referred to as Equality Impact Assessments (EqIAs). This ensures any proposed service, strategy, policy, function, or similar directive is systematically analysed by us under support and direction from our Equality, Diversity and Inclusion function. The process identifies what

effect, or likely effect, it may have on the people who come into contact with the Health Board, including service users and patients.

The Health Board provides interpretation and translation services to support individuals accessing our services who have a difficulty in hearing or seeing, or there is a difficulty in understanding each other's language. In early 2023, the Health Board launched the SignLive service, to support our Deaf and British Sign Language (BSL) users to access our services. Users are able to use SignLive to make phone calls and aid in person communication in situations where a face-to-face interpreter is not available.

We strive to reflect the local population in our workforce. We do this by ensuring staff are equipped with the necessary knowledge and information to understand and work with individuals, groups and populations that historically have not accessed appropriate health services, or have sought the services at a later stage of their illness or condition.

Further information is available in the Accountability Report.

10. Welsh Language Regulations

The Health Board continues to make good progress in our work in relation to Welsh language service delivery. We recognise that communication is key to deliver the best care to all those we service and we therefore note the importance for our Welsh speaking community to be able to receive care and support in their mother tongue.

The Annual Report 2021/22 addresses the statutory duty of Aneurin Bevan University Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120. This report sets out how the Health Board has complied with the Welsh Language Standards requirements from 01 April 2021 - 31 March 2022.

The Annual Report for 2021/22 is available on-line in both Welsh and English
https://abuhb.nhs.wales/files/key-documents/other-reports/welsh-language-standards-annual-report-2021-22pdf/ English

https://bipab.gig.cymru/ffeiliau/key-documents/adroddiad-blynyddol-safonaur-gymraeg-2021-22pdf1/ Welsh

The report for 2022-2023 will be published in September 2023.

11. Financial Management and Performance

The Annual Accounts 2022/23, at Section 3 of the Annual Report and Accounts 2022/23, Page XX, sets out the detailed accounts for the full year to 31 March 2023 for Aneurin Bevan University Health Board. These accounts are prepared under International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period; and
- To submit an Integrated Medium-Term Plan (IMTP) to secure compliance with breakeven over three years.

Under the rolling 3-year duty, introduced with the NHS (Wales) Act 2014, the first assessment of the first statutory financial duty took place at the end of 2016/17 when it was achieved. The Health Board has **not** met its financial duty to breakeven against its Revenue Resource Limit over 3 years 2020-21 to 2022-23.

In relation to the second duty the Health Board did secure WG approval to the IMTP on 13th July 2022. The note in the accounts shows that this duty was achieved. (*Note 2.3 of the Annual Accounts 2022/23).*

Revenue Resource Performance

The Health Board did not meet its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23 period, the Board reported an overspend of £36,348k as shown below:

3 Year Revenue Breakeven Duty	**2020/21** £000	**2021/22** £000	**2022/23** £000	**Total** £000
Underspend Against Allocation	245	249	- 36,842	- 36,348

Capital Resource Performance

In addition to a revenue resource limit the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The target of £40.723m was met in 2022/23 with a small underspend of £43k. The target is measured over a 3-year period as shown in the table below:

3-year capital breakeven duty	2020/21 £000	2021/22 £000	2022/23 £000	Total £000

Underspend against allocation	13	50	43	106

Other Related Targets

- Public Sector Payment Policy
  This target for the Health Board relates to the payment of 95% of its trade creditors within 30 days. In 2022/23, the target was achieved with full year figure of 95.2%.

- Cash Balance
  Welsh Government sets a notional target for Health Boards in Wales to have end of period cash balances not exceeding £6m. For 2022/23, the Health Board ended with an actual cash balance of £4.704m and was therefore within the target.

Long Term Expenditure Trend

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
General Medical Services	**99,491**	**103,343**	**108,993**	**112,524**	**116,217**
Pharmaceutical Services	**24,995**	**22,900**	**27,109**	**25,082**	**25,273**
General Dental Services	**36,232**	**36,608**	**33,079**	**38,030**	**39,817**
General Ophthalmic Services	**8,419**	**8,911**	**8,734**	**9,343**	**8,866**
Other Primary Health Care expenditure	**2,738**	**2,872**	**2,289**	**2,487**	**2,612**
Prescribed drugs and appliances	**95,557**	**102,280**	**106,852**	**106,282**	**114,331**
Total	**267,432**	**276,914**	**287,056**	**293,748**	**307,116**

	£'000	**£'000**	**£'000**	**£'000**	**£'000**
3.2 Expenditure on healthcare from other providers	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Goods and Services from Other NHS bodies	**95,505**	**103,179**	**103,278**	**117,637**	**117,587**
Goods and services from WHSSC / EASC	**136,682**	**144,458**	**161,384**	**177,035**	**198,320**
Continuing Care	**71,481**	**71,005**	**81,347**	**83,675**	**86,006**
Other	**46,323**	**61,107**	**71,795**	**85,054**	**72,240**
Total	**349,991**	**379,749**	**417,804**	**463,401**	**474,153**

3.3 Expenditure on Hospital and Community Health Services

	£'000	**£'000**	**£'000**	**£'000**	**£'000**
	2018-19	**2019-20**	**2020-21**	**2021-22**	**2022-23**
Staff Costs	**524,092**	**579,760**	**671,972**	**714,255**	**762,081**
Non Pay	**149,022**	**152,277**	**172,611**	**191,827**	**200,118**
Depreciation and Impairments	**23,596**	**23,197**	**96,361**	**31,056**	**30,804**
Losses, special payments and irrecoverable debts	**2,024**	**3,154**	**1,886**	**2,831**	**1,526**
Other operating expenses	**7,875**	**7,990**	**8,526**	**11,009**	**9,538**
Total	**706,609**	**766,378**	**951,356**	**950,978**	**1,004,067**

Long Term Revenue Performance Trend

2. Financial Duties Performance

2.1 Revenue Resource Performance

Annual financial performance

	2018-19	2019-20	2020-21	2021-22	2022-23	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Net operating costs for the year	1,226,261	1,319,803	1,551,819	1,598,803	1,676,282	4,826,904
Less general ophthalmic services expenditure and other non-cash limited expenditure	(2,149)	(161)	(1,423)	(58)	148	(1,333)
Less revenue consequences of bringing PFI schemes onto SoFP	0	0	0	0		0
Total operating expenses	1,224,112	1,319,642	1,550,396	1,598,745	1,676,430	4,825,571
Revenue Resource Allocation	1,224,347	1,319,674	1,550,641	1,598,994	1,639,588	4,789,223
Under /(over) spend against Allocation	235	32	**245**	**249**	(36,842)	(36,348)

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23.

The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2023/24 IMTP.
The health board received £23m of strategic cash support in 2022-23.

2.2 Capital Resource Performance

	2018-19	2019-20	2020-21	2020-21	2022-23	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Gross capital expenditure	141,139	133,286	112,376	52,167	41,011	205,554
Add: Losses on disposal of donated assets	0	7	0	0	2	2
Less NBV of property, plant and equipment and intangible assets disposed	(81)	(555)	(884)	(3,115)	(61)	(4,060)
Less capital grants received	(45)	(93)	(333)	(22)	(62)	(417)
Less donations received	(121)	(300)	(201)	(166)	(210)	(577)
Charge against Capital Resource Allocation	140,892	**132,345**	**110,958**	**48,864**	**40,680**	**200,502**
Capital Resource Allocation	140,933	132,373	110,971	48,914	40,723	200,608
(Over) / Underspend against Capital Resource Allocation	41	28	**13**	**50**	**43**	**106**

In 2018/19 £120m out of the £141m spend related to the new Grange University Hospital.

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2020-21 to 2022-23.

The Health Board's financial statements have been prepared in accordance with the 2022-23 NHS Wales Manual for Accounts. The accounting policies contained in that manual follow the 2022-23 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

The Manual for Accounts makes clear that accounts should be prepared on a going concern basis where there is the anticipated continuation of service in the future. The assumption has been made that the services of Aneurin Bevan University Health Board will continue in operation. Consequently the going concern basis has been adopted.

12. Conclusion and Forward Look

As an organisation our mission is to improve population health, and, through doing this, reduce the health inequality that exists across our communities. The current 18-year gap in healthy life expectancy between our wealthiest and poorest communities is significant. It is the consequences of inequality that mean a greater number of citizens require our services. Sadly, the COVID-19 pandemic has worsened the gap. Therefore, as we look to the future, we must relentlessly focus on reducing health inequality as part of improving overall population health.

Our Integrated Medium-Term Plan (IMTP) 2022-25 and 2023-26 build on the life course approach, whilst recognising the current operational demands and then focussing on realistic, sustainable recovery.

The plan is based on a realistic assessment of delivery over the next three years; it is optimistic in its outlook, recognising the need to build on the service changes achieved over the last few years, and it focusses on making those changes sustainable, to meet the long-term needs of our communities.

At the forefront of all service delivery is person centred care. We remain committed to further improving patient related experience and outcomes, learning and listening to our staff and patients.

Aneurin Bevan University Health Board
Section 2: Accountability Report
1st April 2022 – 31st March 2023

INTRODUCTION TO THE ACCOUNTABILITY REPORT

Aneurin Bevan University Health Board is required to publish, as part of our annual reporting, an Accountability Report. The purpose of the Accountability Report section of the Annual Report has been designed to demonstrate the ways in which the Health Board is meeting its key accountability and reporting requirements.

This Accountability Report has three sections:

1. Corporate Governance Report

This explains the composition of the Health Board, its governance structures and arrangements and how the Health Board seeks to achieve its objectives and responsibilities to meet the needs of the people we serve. The Corporate Governance Report includes:

A. The Directors' Report
B. The Statement of the Chief Executive as the Accountable Officer and the Statement of Directors' Responsibilities in respect of the Accounts
C. The Annual Governance Statement.

2. Remuneration and Staff Report

This section contains information about the staff of the organisation, particularly focusing on the remuneration of its Board and senior management, fair pay ratios and other staff information, such as sickness absence rates.

3. Senedd Cymru/Welsh Parliament Accountability and Audit Report

This section contains a range of disclosures on the regularity of expenditure, fees, charges, compliance with cost allocation, material remote contingent liabilities, long-term expenditure trends and charging requirements set out in HM Treasury guidance.

Corporate Governance Report 2022/23

Including:

- **A. The Directors' Report**
- **B. 1. The Statement of the Chief Executive as the Accountable Officer**
- **B. 2. The Statement of Directors' Responsibilities in respect of the Accounts**
- **C. The Annual Governance Statement**

SECTION A: THE DIRECTORS' REPORT

Aneurin Bevan University Local Health Board is a statutory body that was established on 1st June 2009 and became operational on the 1 October 2009 under *The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778), "the Establishment Order".*

The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations") set out the constitution and membership arrangements of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Aneurin Bevan University Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights.

In addition, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations")*, and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the Government's legislation website:
http://www.legislation.gov.uk/wsi/2009/779/contents/made

Further detail on the Board's membership and composition during 2022/23 is available within Section C: The Annual Governance Statement.

Board Members' Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis.

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2023. This information is

available on the Health Board's Internet site and can be accessed by following this link.

Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed on page 41 of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

The Board is aware of the potential impact that the operation of the Health Board has on the environment and it is committed to wherever possible:

- Ensuring compliance with all relevant legislation and Welsh Government Directives;
- Working in a manner that protects the environment for future generations by ensuring that long term and short-term environmental issues are considered; and
- Preventing pollution and reducing potential environmental impact.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the Health Board's estate.

The Board's Annual Report for 2022/23 and Integrated Medium Term-Plan (IMTP) 2022-25 (approved March 2022) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2022/23 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2022/23.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the cost allocation and charging requirements set out in HM Treasury guidance during the 2022/23 year.

SECTION B(1): STATEMENT OF THE CHIEF EXECUTIVE AS THE ACCOUNTABLE OFFICER OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer. As Accountable Officer, I confirm that, as far as I am aware, there is no relevant audit information of which the Health Board's Auditors are unaware, and I have taken all the steps that ought to have been taken to make myself aware of any relevant audit information and that the Health Board's auditors are aware of that information.

As Accountable Officer, I confirm that the Annual Report and Accounts 2022/23 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

As Accountable Officer, I am responsible for authorising the issue of the financial statements on the date they are certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

_____

Name: Nicola Prygodzicz, Chief Executive **Date:**

SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2022/23

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Aneurin Bevan University Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Ann Lloyd, Chair
Dated:

Nicola Prygodzicz, Chief Executive
Dated:

Robert Holcombe, Director of Finance and Procurement
Dated:

SECTION C: ANNUAL GOVERNANCE STATEMENT, 2022/23

SCOPE OF RESPONSIBILITY

The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

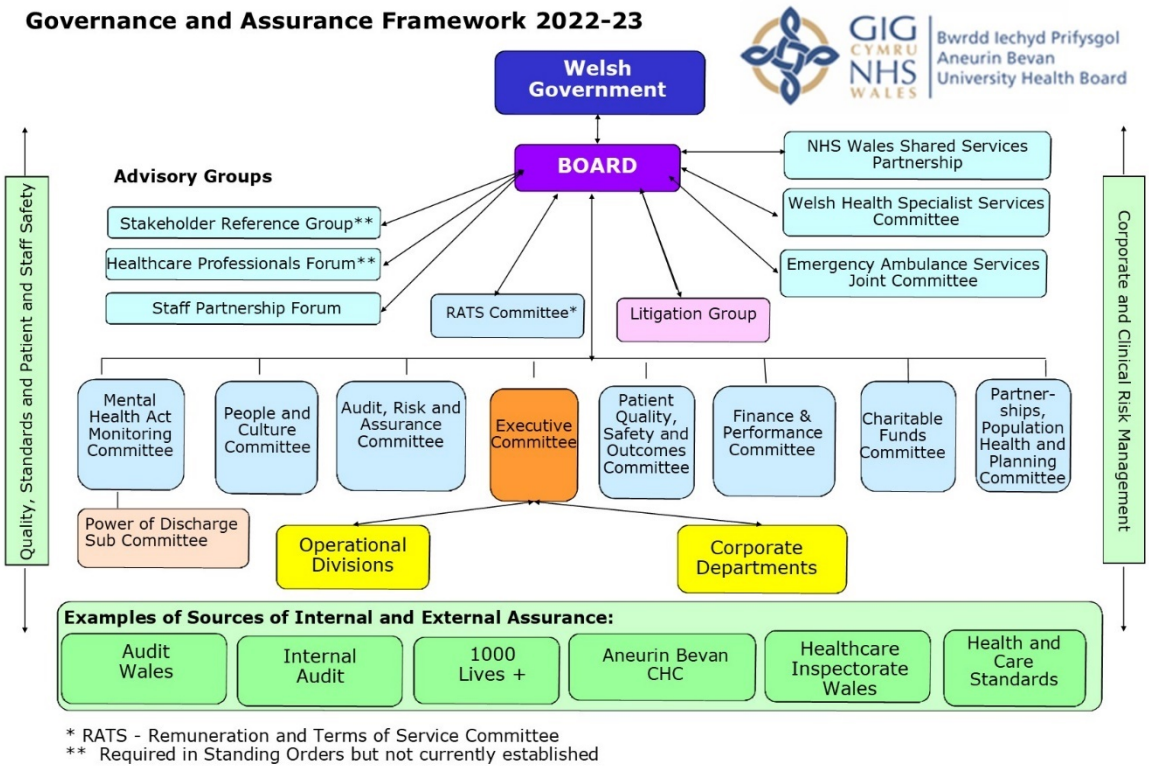
The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

Welsh Government's Escalation and Intervention Arrangements for NHS Wales sets out the collective arrangements in place between the Welsh Government and external review bodies for identifying and responding to serious issues affecting NHS service delivery, quality and safety of care, and organisational effectiveness. In 2022/23, Aneurin Bevan University Health Board remained under routine arrangements.

OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the Board's Assurance Framework and a range of corporate policies set by the Health Board make up the Governance and Assurance Framework and arrangements of the organisation.

The diagram overleaf outlines the governance and assurance framework in place during 2022/23:



Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2022/23 and attendance at Board and Committee meetings respectively for this period.

There has been significant change to the membership of the Board during 2022/23, as outlined in Table 1 below:

TABLE 1		
Name	**Designation**	**Dates (if less than full year)**
Executive Directors		
Nicola Prygodzicz	Chief Executive	From 05/09/2022
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT/ Interim Deputy Chief Executive	Until 04/09/2022
Glyn Jones	Interim Chief Executive	Until 04/09/2023
Glyn Jones	Deputy Chief Executive	05/09/2022 to 23/09/2022
Christopher Dawson-Morris	Interim Director of Planning and Performance	From 05/09/2022 to 03/04/2023
Hannah Evans	Director of Strategy, Planning and Partnerships	From 01/04/2023
Rob Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare	Until 13/11/2022

Rob Holcombe	Director of Finance and Procurement	From 14/11/2022
Dr James Calvert	Medical Director	Until 23/09/2022
Dr James Calvert	Medical Director / Deputy Chief Executive	From 24/09/2022
Sarah Simmonds	Director of Workforce and OD	Full Year
Rhiannon Jones	Director of Nursing	Until 05/07/2022
Jennifer Winslade	Director of Nursing	From 08/08/2022
Linda Alexander[3]	Interim Director of Nursing	25/06/22 to 14/08/2022
Peter Carr	Director of Therapies and Health Sciences	Full Year
Dr Sarah Aitken[1]	Director of Public Health and Strategic Partnerships	Until 05/01/2023
Tracy Daszkiewicz[1]	Director of Public Health	From 01/04/2023
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	Full Year
Independent Members		
Ann Lloyd	Chair	Full Year
Pippa Britton	Interim Vice Chair	Full Year
Katija Dew[2]	Independent Member (Third Sector)	Full Year
Shelley Bosson	Independent Member (Community)	Full Year
Louise Wright	Independent Member (Trade Union)	Full Year
Richard G Clarke	Independent Member (Local Authority)	Full Year
Professor Helen Sweetland	Independent Member (University)	Full Year
Paul Deneen	Independent Member (Community)	Full Year
Iwan Jones	Independent Member (Finance)	From 04/04/2022
Dafydd Vaughan	Independent Member (Digital)	From 09/05/2022
Vacant (Pippa Britton's Substantive position)	Independent Member (Community)	Full Year
Directors in Attendance**		
Leanne Watkins	Director of Operations	Full Year
Special Advisors to the Board***		
Phil Robson	Special Advisor to the Board	Full Year
Associate Members****		
Keith Sutcliffe	Chair, Stakeholder Reference Group	Until 30/11/2022 and vacant thereafter
Vacant	Chair, Health Professionals Forum	Full Year
Vacant	Director of Social Services	Full Year

Director of Corporate Governance*****		
Rani Dash (nee Mallison)	Director of Corporate Governance	Full Year

** In October 2021, Emrys Elias, Vice Chair, began a temporary role as Chair of Cwm Taf Morgannwg University Health Board in October 2021. Whilst interim arrangements have been put in place, the Health Board has been advised by Welsh Government not to appoint a permanent replacement for 18 months. Pippa Britton has therefore been appointed Interim Vice Chair, leaving her substantive role as Independent Member (Community) vacant on a temporary basis. The appointment process for a Vice Chair has now been undertaken and an appointment by the Minister is awaited*

***The Director of Operations is not an Executive Post. The Director of Operations is therefore not a Board Members and attends meetings of the Board without voting rights.*

****The Board has discretion to appoint Special Advisors to support it in achieving its responsibilities. Special Advisors are not Board Members and therefore attend meetings of the Board without voting rights.*

*****Associate Members are Members of the Board but do not hold voting rights.*

****** Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within the LHB. The Director of Corporate Governance is responsible for providing advice to the Board as a whole and to individual Board members on all aspects of governance.*
On 14th March 2022, the Remuneration and Terms of Service Committee approved a change of operating title for the Board Secretary role to Director of Corporate Governance.

[1] Director of Public Health - During the vacancy period 05/01/23 to 01/04/2023, Stuart Bourne and Eryl Powell, Deputy Directors of Public Health, provided advice to the Board and attended meetings in their deputy roles.

[2] Katija Dew – Term of office ended 31/3/2023

[3] Linda Alexander – Linda Alexander assumed interim executive director responsibilities from 25/06/22 due to Rhiannon Jones taking annual leave from 25/06/22 to 05/07/22. Linda Alexander held interim executive director responsibilities until 07/08/22 when Jennifer Winslade commenced in role as Executive Director of Nursing on 08/08/22. The period of 08/08/22 to 15/08/22 was used as a handover period.

As at 31 March 2023, following Ministerial Public Appointment campaigns, the Minister for Health and Social Services is currently considering appointments to the role of Vice Chair and Independent Member (Third Sector).

Due to the number of interim positions within the Board during 2022/23, the Chair and Chief Executive Officer, with the Remuneration and Terms of Service Committee, worked to stabilise changes within the Executive Team and ensure robust induction, development and succession planning for Board Members. This included permanent recruitment to the roles of Chief Executive, Director of Finance and Procurement and Director of Nursing during 2022/23. In addition, the Director of Public Health and the Director of Strategy, Planning and Partnerships commenced in role on 1st April 2023.

The Role of the Board

The Board, chaired by Ann Lloyd CBE, has been constituted to comply with the Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Member positions, Special Advisors and other senior managers who routinely attend Board Meetings. The full membership of the Board and their lead roles and committee responsibilities are outlined in **Attachment 1**.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation and the Chief Executive as Accountable Officer, is responsible for maintaining appropriate governance structures and procedures.

In summary, the Board:

- Sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- Establishes and maintains high standards of corporate governance;
- Ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- Monitors progress against the delivery of strategic and annual objectives; and
- Ensures effective financial stewardship by effective administration and economic use of resources.

The Health Board must agree Standing Orders for the regulation of proceedings and business which are designed to translate the statutory requirements set out in the LHB (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day to day operating practice, and, together with the adoption of a scheme of matters reserved to the Board; a scheme of delegations to officers and others; and Standing Financial Instructions, they provide the regulatory framework for the business conduct of the Health Board and define - its 'ways of working'. These documents, together with the range of corporate policies set by the Board make up the Governance Framework.

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2022/23.

In recognition of the Board's strategic priorities for 2022/23 and the strategic risks it holds, a revised committee structure was approved by the Board in March 2022 and implemented from 1st April 2022. There have been no changes to this structure in 2022/23. The committee structure has enabled an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness.

During 2022/23, the following Committees were in place:

- Audit, Risk & Assurance Committee
- Patient Quality, Safety & Outcomes Committee
- People & Culture Committee
- Finance & Performance Committee
- Partnerships, Population Health and Planning Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Litigation Group

The Terms of Reference and Operating Arrangements, meeting agendas and papers for each of these Committees can be found on the Health Board's website.

These Committees are Chaired by Independent Members of the Board. The Chair of each Committee reports regularly to the Board on the committee's activities. This contributes to the board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. In addition, and in-line with Standing Orders, each committee is required to produce an annual report.

In addition to the Board's formal meetings and formal Committee meetings, the following informal arrangements have been established to support the Board to fulfil its responsibilities:

- Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
- Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation; and

- Board Strategic Planning Sessions, held quarterly, to allow the Board informal development time to discuss collectively strategic developments and horizon planning.

Conducting Business with Openness and Transparency

In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the Board and Committees are required to meet in public. Following the COVID-19 pandemic where the public health risk posed, resulted in limitations on public gatherings, the Board and its Committees moved to meeting in a virtual setting meaning that it was not possible to allow the public to attend meetings of the Board and Committees.

Board members resumed meeting in person to conduct Board meetings in May 2022. At this time, the Health Board did not have the capacity to enable physical attendance of observers, which meant that members of the public were unable to attend meetings in person. The Board took the decision at that time in the best interests of protecting the public, our staff and Board members.

Since November 2022, the Microsoft Teams link has been published with the agenda and on social media channels to enable members of the public to observe Board meetings in real time. Members of the public have been able to attend in person since January 2023. Meetings of all Board meetings in 2022/23 were recorded and published to the Health Board's You Tube Channel within 24 hours for public viewing.

During 2022/23, the Board's committees have continued to meet virtually and, due to capacity constraints, the Health Board has not been able to stream these in real-time for the public's viewing. Work is underway to address this in 2023/24 to ensure that the Health Board's business operates with full transparency and openness.

As the Health Board has not been able to allow the public to attend all meetings of its committees during 2022/23, the Health Board has not complied with its Standing Orders in this regard.

It is acknowledged that a hybrid approach to meetings will continue to be required in the future and the Health Board will work to ensure members of the public can attend meetings in person and/or virtually.

To ensure Board and Committee business was conducted in as open and transparent manner as possible the following actions were taken:

- All Board and Committee meeting agenda packs have been published to the Health Board's website in advance of meetings;
- Meetings of the Board have been recorded and published to the Health Board's You Tube Channel within 24 hours;
- The Health Board's Annual General Meeting in July 2022 was livestreamed;

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published into the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Board Strategic Planning Sessions discussing plans and ideas often in their formative stages.

Meetings of the Board and its Committees are formally recorded with minutes considered for approval at the next available meeting, respectively. In addition, the Director of Corporate Governance maintains Decision Logs for all decisions taken by the Board and the Executive Team.

Items considered by the Board in 2022-23

During 2022-23, the Board held 7 meetings:

- 6 routinely scheduled bimonthly meetings
- 1 additional meeting in June 2022 to formally approve the Annual Report and Accounts for 2021/22, following detailed consideration by the Health Board's Audit, Risk and Assurance Committee.

In addition, the Board held its Annual General Meeting on 27th July 2022.

All the meetings of the Board in 2022/23 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2022/23 are outlined below.

Further information can be obtained from the published Board meeting papers on the Health Board's website via the following link.

a) Business Cases:

- Approved the submission of the **Radiotherapy Satellite Unit Business Case** to Welsh Government.
- APPROVED the submission of the **Adult Mental Health and Learning Disabilities Specialist Inpatient Services Unit (SISU) Outline Business Case** to the Welsh Government.
- Supported, in principle, the case for change for the **Velindre Cancer Centre**. However, requested that Velindre NHST reconsider the finance and economic cases for the Board's further consideration.

b) Plans/Strategies/Policies/Service Change

- Approved the Health Board's **People Plan** and associated documentation.
- Approved a recommendation to establish a **Service for Adults with Attention Deficit Hyperactivity Disorder (ADHD)** in Aneurin Bevan

University Health Board, noting that this would be subject to evaluation at an appropriate point.

- Endorsed the **Six Goals for Urgent and Emergency Care Programme Plan.**
- Approved the Aneurin Bevan University Health Board **Arts in Health Strategy 2022-2027.**
- Approved the implementation of the **Community Therapy MSK Pathway**, recognising that ongoing discussions to support implementation were required.
- Received the **Winter Plan 2021/22 evaluation.**
- Received an update on the implementation of the **Digital Strategy,** ongoing actions to mitigate risks and achieve progress.
- Approved the proposed targeted engagement regarding the future configuration of the **South Wales Cochlear Implant and Bone Conduction Hearing Implant Device Service**.
- Reviewed the current arrangements for **Midwifery Led Services within ABUHB** and supported a proposal to engage with the public on making a temporary service change permanent, with further staff consultation.
- Approved the Health Board's **Research and Development Strategy**.
- Agreed to the development and implementation of an **Anti-Racist action plan** for the Health Board.
- Approved the Draft Opening **Capital Programme for 2023/24**.
- Approved the **Integrated Medium-Term Plan 2023-26**.
- Approved the **Quality Strategy.**
- Approved the **Patient Experience and Involvement Strategy.**
- Endorsed the **South East Wales Regional Ophthalmology Strategy**.
- Endorsed the **Gwent Public Service Board Well Being Plan**.

c) Governance and Assurance

- Received the **Board's Annual Review of Effectiveness 2021/22** report.
- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act.**
- Approved the **Annual Report and Accounts 2021-22.**
- Approved the **Charitable Funds Annual Accounts and Annual Report 2021-22**
- Received the following **Annual Reports**:
    - Trade Union Partnership Forum
    - Cancer Services
    - Welsh Language Standards
    - Equality Report
    - Director of Public Health
- Received the **Audit Wales Annual Audit Report and Structured Assessment.**
- Endorsed the **Accelerated Cluster Development programme governance arrangements** and **approved the proposed governance of Neighbourhood Care Networks.**

d) Routine Business

- Ratified actions taken by the Chair, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's financial performance and the related risks being managed by the organisation.
- Considered the Board's performance against key local and national targets and the actions being taken forward to improve performance.
- Received assurance reports from the Committees and Advisory Groups of the Board.
- Received update reports from the Executive Team in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the Corporate Risk Register and sought assurance on the management of mitigating actions.

e) Patient Experience and Public Engagement

In March 2023, the Board approved its Patient Experience & Involvement Strategy. The Strategy's goals and objectives are to improve services and their effectiveness, and safety and to improve people's experiences. It encompasses the Health Board's intent to engage patients, families, carers, staff and the wider community, with a commitment to listen to feedback, learn and therefore improve healthcare across all of our services.

The Health Board's key principles, as set out in the Strategy, are to:

- Work in partnership with patients, families, carers, staff and communities, and listen to their perspective.
- Enhance our efforts to obtain real-time feedback.
- Use people's feedback proactively to identify quality improvement opportunities.
- To put things right that may have gone wrong, helping people to share their experience and to restore their confidence.
- Through listening and learning, develop best practice and support staff to deliver excellent person-centred care.

The Board has remained committed to hearing and learning from the experience of staff and patients. During 2022/23 the Board received patient/staff stories in respect of:

- **Long COVID – Adferiad -** experience of using the service and the impact of long-COVID on the individuals health & wellbeing
- **Virtual Ward -** a place based structured, face-to-face or virtual multi-disciplinary team (MDT) conversation between a range of multi-disciplinary and multi-sector professionals, where people/patients with a variety of complex and inter-related issues are discussed and care planning takes place.
- **'Bob's Story - What Matters to Me'** - highlighting the importance of dignity and respect for patients.

Throughout 2022/23, the **Aneurin Bevan Community Health Council** attended meetings of the Board to provide an overview of recent issues of

concern and positive observations or public feedback being addressed by the Community Health Council in relation to the planning and delivery of health services in Gwent. In addition, the Board held joint meetings with the Community Health Council's management team and full Council.

Items considered by Committees of the Board

During 2022/23, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in the assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms. The Committees also considered and advised on areas of local and national strategic developments and new policy areas.

An overview of the key areas considered by the Committees of the Board is provided below:

Audit, Finance and Risk Committee	Among the key issues considered by the Committee during 2022-23, as outlined in the Committee's Work Programme, the following were also considered: • Update on the Health Board's Outpatient Transformation Project • Update on the Estates Efficiency Framework • Update on Asset Verification • Report on the Welsh Health Circular (WHC) Tracker • Report on the Implementation of the Governance Priorities set out within the IMTP 2022-25 • Welsh Health Specialised Services Committee Governance Arrangements Audit Tracker Report (for those recommendations relating to Health Board governance arrangements) • Audit Wales Review of Quality Governance Arrangements • Audit Wales - Five-year Strategy 'Assure, Explain, Inspire' Report • Audit Wales - Welsh Community Care Information System Report • Audit Wales - Tackling the Planned Care Backlog in NHS Wales Report • Audit Wales - Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report • Audit Wales - Continued COVID-19 response alongside growing patient demand Report • Audit Wales – Consultation on Fee Scales 2023 /2024 • Audit Wales - £6.5 million of fraud and overpayments identified by National Fraud Initiative in Wales • Audit Wales - Making Equality Impact Assessments more than just a tick box exercise Report • Audit Wales Review of Efficiency Savings Arrangements Report

	• Audit Wales – Audit of Accounts Report 2021/22 The Committee reviewed and approved the audit strategies and plans from Audit Wales and Internal Auditors, NWSSP Audit & Assurance Services and received audit reports produced in support of them during 2022-23. In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile. During the year the Committee received Internal Audit reports in line with the agreed programme for 2021-22 and 2022-23, including the management response from the relevant Executive Director. In total, 32 internal audit reviews were carried out during the year, including six that were carried over from 2021/22. Further detail on the work of internal and external audit in 2022/23 is provided later on in this report, under the section on Internal Control.
Patient Quality, Safety and Outcomes Committee	Among the key issues considered by the Committee during 2022-23, as outlined in the Committee's Work Programme, the following were also considered: • An overview of the new **Dementia Standards** and the launch, on the 6th April 2022, of the All-Wales Hospital Dementia Charter • Overview of compliance and performance against **National Clinical Audit and Local Clinical Audit Arrangements** • Compliance with **Cleaning Standards,** including Benchmarking Data, and Actions underway to address associated issues and risks • An update of progress following the initial presentation in September 2021 of the review of **Access Arrangements in General Medical Services (GMS)** undertaken in June 2021 • An update on the work being undertaken in theatres and scheduled care, relating to **theatre safety,** following concerns regarding an increase in 'Never Events' in surgical and theatres directorates. • An overview of the **Covid-19 investigative framework** • **Learning from Death Report** and the statutory requirement for all deaths in Wales, in both primary and secondary care, to be subject to scrutiny by the Medical Examiner. • Health Board's approach to continued organisational learning in respect of **Operation Jasmine.** • Overview of Enhanced Care: linking provision, cost and outcomes • The Health Board's plan and progress in response to the Welsh Government **'Six Goals for Urgent and Emergency Care'** and how these plans have now been aligned within the Health Board's 'Six Goals' Programme Plan. • Assurance in respect of work undertaken to address required improvements outlined in the **National Clinical Audit of Psychosis** with respect to the Early Intervention Service (EIS) (2020/2021). • **Cancer performance** including identified improvement actions to address the current challenges.

	• Report outlining the Health Board's action plan in response to the **national review of Venous Thromboembolisms**. • **Safeguarding Annual Report**, including progress, performance, risk and learning together with an overview of emerging themes and trends. • **Infection Prevention and Control Annual Report,** outlining the infection prevention work undertaken in 2021/22, management arrangements and progress against performance targets. • An update on the review of care for individuals with **Learning Disabilities** • Overview of the Health Board's contractual arrangements for **WAST inter-site transfers**. • Health Board's current position and governance arrangements in relation to **Health and Safety Compliance**. The Committee also received various external reports, including: • Regular reports outlining progress of the delivery against recommendations and outstanding actions from **HIW inspections** conducted across the Health Board. • **Internal Audit Review, The Grange University Hospital Quality Assurance** • **Internal Audit Review, Falls Management** • **Audit Wales Review of ABUHB Quality Governance Arrangements**, which concluded that the Health Board had clear, articulated corporate arrangements for quality governance and key areas of quality and safety; however, further improvement was required at Divisional and Directorate level. • **HIW Unannounced visit to The Grange University Hospital**, triggered by ongoing pressures in the urgent care system. Overall, HIW were not assured that all systems and processes in place were sufficient to ensure all patients were consistently receiving acceptable standards of safe an effective care, although the hard work of staff was recognised. The Committee maintained a focus on progress on the issued identified. • Discussion of the key points from the **Ockenden Review** and identified actions being taken in Wales to review the report and extract learning. • **HMP Prison Services Self-Assessment,** based upon recommendations taken from HIW's review of the Quality Governance Arrangements within Swansea Bay University Health Board, for the delivery of healthcare services to Her Majesty's Prison Swansea. The Committee also approved the **Clinical Audit Strategy** - to support the delivery of a meaningful programme of audit designed to provide assurance and inform quality improvement across the Health Board.

Charitable Funds Committee	• Scrutinised applications for charitable funds • Reviewed charitable funds income and expenditure • Considered and endorsed the Charitable Funds Accounts and Annual Report 2021/22 • Received the Audit Wales – Audit of Accounts Report 2021/22
Mental Health Act Monitoring Committee	The role of the Mental Health Act Monitoring Committee (MHAMC) is to monitor and review the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983. The Committee therefore receives a quarterly report which provides assurance to the Committee on the compliance with the legislative requirements of the Mental Health Act. Throughout 2022/23, the Committee has continuously discussed the impact the pandemic has had on demand and the level of acuity in mental health services. The Committee discussed the need to increase the number of Mental Health Act Managers and the need to strengthen recruitment processes in this area. A revised Mental Health Act Managers Policy has been developed for implementation in early 2023/24. A **Power of Discharge Sub-Committee** has been established as a formal sub-committee of the MHAMC. The membership of this Committee is comprised of Associate Hospital Managers and provides advice and assurance that the processes associated with the discharge of patients from compulsory powers, used by the Sub-Committee, are being performed correctly and in accordance with legal requirements. The Sub-Committee reports routinely to the Committee for assurance and developmental purposes. In addition, the MHAMC received an overview of the pilot projects and work to support people in the Gwent area who are experiencing a mental health crisis.
People and Culture Committee	Among the key issues considered by the Committee during 2022-23, as outlined in the Committee's Work Programme, the following were also considered: • Regular **Reports from the Director of Workforce and OD**, including overviews of employee relations matters. • An overview of the **People First Staff Engagement and Reconnection**, including a summary of the first two phases of the plan. • People Plan Updates • A **Review of the Equality Impact Assessment (EQIA) Process** (*More than Just a Tick Box Exercise),* including the proposal for the establishment of an integrated EQIA group.

	• Regular **Agile Working Updates**, including an overview of the work carried out by the Health Boards Agile Delivery Board. • Committee Strategic Risk Report, including the **Workforce Divisional Risk Register**, providing an overview of progress against mitigation of risk. • **Workforce Performance Dashboard** incorporating Key Performance Indicators. • **Employee Wellbeing Survey Update**, including results from the surveys to help inform programs of work and well-being interventions. • An overview of the Health Boards compliance with the Welsh Government **More Than Just Words 2022-2027** initiative. • Assurance on Delivery of Actions and Delivery associated with the Health Board being an **Employer of Choice**. • An update on the Health Boards **Variable Pay Action Plan**, including an overview of the work delivered through the Agency Reduction Programme Board. • An overview of the Health Boards **Medical Training Risk Register,** including alignment with the General Medical Council (GMC) set standards, as monitored by Health Education and Improvement Wales (HEIW). • An overview of the Health Boards **Medical Appraisal and Revalidation** process. The Committee also received external reports, as below; - • Audit Wales Report, **'Taking Care of the Carers'** and the Health Board's Management Response.
Finance and Performance Committee	Amongst the key issues considered by the Committee during 2022-23 were the following: **Finance** • **Financial Performance** updates outlining the Health Board's financial performance, financial targets, statutory financial duties and forecast position. • The Health Board's **approach to sustainability** to deliver financial balance as part of the IMTP. • Overview of the '2022/2023 Efficiency Review' of the Health Board, and a presentation of the '**Efficiency Opportunities Compendium'**, which captured business intelligence to support Divisions to improve efficiencies, based on best practice. • Overview of the utilisation of **Covid Recovery funding** received in financial year 2021-22. • **Value Based Healthcare Achievement Annual Report 2021/22**, which demonstrated the collaborative work between the Value-Based healthcare teams and operational teams to deliver Value-Based healthcare across a range of priority programmes.

	• Presentation of the **Variable Pay Savings Plan** (Agency Reduction), which would be monitored and reported to the Health Boards Strategic Nursing Workforce Group • Financial Understanding of **Health Board Commissioned Services**, including assessing needs, planning, and prioritising, purchasing, and monitoring health services, providing the best health outcomes for the Health Board's population. • Update on the **forecast revenue resource position** for the financial year 2022/23. • **Budgetary Control and Finance Control Procedure,** describing key financial controls and governance rules and behaviours which the organisation had established to ensure expenditure is managed within available resources. • Financial Outlook & 2023/24 Allocation letter Briefing • 2022/23 Forecast Closing Underlying Position • 2023/24 Budget Planning (Delegation) Principles • Efficiency Opportunities 2023/24 **Performance** • A live demonstration of the Health Board's automated version of the **Performance Management Dashboard**. • Performance Exception Reporting: o **Cancer,** illustrating the current cancer performance and identifying improvements to address any challenges. o **Six Goals of Urgent and Emergency Care**, outlining the Health Board's "Six Goals for Urgent and Emergency Care" Programme and associated performance and financial status. • **Information Governance Performance Indicators** providing performance information regarding the Health Board's compliance with the General Data Protection Regulation and Data Protection Act 2018. • Getting it Right First Time Reviews (GIRFT): • Overview of the **Review of Stroke Services Report** • and the approach to optimising patient care and outcomes. • Update on **Orthopaedic Improvement Programme**, noting 3 key areas of focus - reduce clinical variation, reduce the backlog and value for money.
Partnerships, Population Health and Planning Committee	Amongst the key issues considered by the Committee during 2022-23 were the following: • An overview of Work of the **Gwent Public Service Board (PSB)**, including an update in respect of developing a Marmot Region via the Public Services, to reduce health inequalities across Gwent. • An overview of the Health Boards **Integrated Medium Term Plan 2022-2026**. • An overview of the Health Boards **Decarbonisation Strategy** and updates on progress of the Decarbonisation Framework 2022/23.

	• An update on progress of **Regional Planning** in respect of regional service planning programmes of work being undertaken in collaboration with health board colleagues across Southeast Wales. • An update on the development and delivery of a **Strategy for Mental Health Services in Gwent**. • An update on the Health Boards key Clinical Futures models of care and links to the revised **Clinical Futures Programme** Priorities. • An update on the development and delivery of a **Strategy for Agile Working in ABUHB**. • An overview of the Gwent Public Health Team' coordination of the delivery of the **Gwent Marmot Region programme**, in partnership with organisations in Gwent, and under the governance of Gwent PSB. • An overview of meetings of the **Regional Partnership Board**, including discussion around topics raised as a concern. • An update of the **Redesigning Services for Older People Programme**, including an overview of the review of Care of the Elderly/Frailty pathways and service delivery models aligning to the IMTP. • An update on the **6 Goals for Urgent and Emergency Care**, including an evaluation of the plans for **Same Day Emergency Care (SDEC)**. • An overview of the successful delivery of the Health Board's **Capital Programme 2021-2022**. • Report regarding the **Third Wales Wellbeing Survey** • Committee Risk Report The Committee also received various external reports, including; - • The **Health and Wellbeing Alliance Report, 'Mind the gap: What's stopping change'**, with a focus on the cost-of-living crisis and the rose in inequalities in Wales. • The Committee received the Audit Wales report, **'Public Sector Readiness for Net Zero Carbon by 2030; evidence report**'

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2022/23. Topics covered at these sessions included:

- Operation Jasmine
- Urgent and Emergency Care System and Pressures
- Violence against Women, Domestic Abuse and Sexual Violence
- Arts for the Grange Programme and Arts in Health Strategy
- Declaration of Business Continuity – Reflection and consequent actions
- Cardiac Rehabilitation Heart Failure Project
- Duty of Quality and Duty of Candour
- Accelerated Cluster Development Programme
- Quality Improvement
- Cyber Resilience
- WHSSC - 10 Year Strategy for Specialised Services and an overview of Performance

- Primary Care Sustainability, Risk & Issues
- Patient and Public Participation in Health Service Changes
- Developing High Quality Care Cultures, including Compassionate Leadership
- Quality and Patient Experience Strategy
- Development of an Outline Business Case for a Specialist Mental Health and Learning Disability Specialist In-Patient Services Unit
- Risk and Assurance, including developing a Risk Appetite Statement
- Medical Workforce Planning, Risk & Issues

In-line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. In February 2023 the Board was asked to undertake individual assessment of its effectiveness during 2022/23, using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. The outcome of these self-assessments will be discussed collectively by the Board at the end of May 2023.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

From 2023/24, Committees will undertake a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

Aneurin Bevan University Health Board's Standing Orders require the Board to establish three advisory groups. These allow the Board to seek advice from and consult with staff and key stakeholders. They are the:

- Stakeholder Reference Group;
- Local Partnership Forum; and
- Healthcare Professionals' Forum.

Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's website.

Stakeholder Reference Group (SRG)

Aneurin Bevan University Health Board established its Stakeholder Reference Group (SRG) in 2010.

The SRG's role has been to provide independent advice on the Health Board's business. including: Early engagement and involvement in the determination of the Health Board's overall strategic direction; the provision of advice on specific service proposals prior to formal consultation; as well as feedback on the impact of the Health Board's operations on the communities it serves. The SRG should provide a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the Health Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the Health Board's decision making.

Since its establishment, the Health Board's engagement arrangements have evolved and continue to develop and mature. In particular, the COVID-19 pandemic has required the Health Board to engage with our stakeholders and communities in new and different ways.

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviews and redesigns the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG is currently being prepared for consideration by the Board.

In the meantime, the Health Board continues to work alongside partners to engage and involve people who others are also seeking to engage. This enables strong partnership working, the sharing of resource and the ability to collaborate regarding joint solutions to challenges shared. Many organisations have been extremely generous in enabling our participation in their existing activities. The Health Board has previously attended:

- Local Authority Community Talk to Us Sessions, Warm Spaces and Cost of Living events;
- Housing Association Resident Complexes and events;
- Health & Wellbeing events and Freshers Fairs at Coleg Gwent Campuses; and
- School Parents evenings, coffee mornings and PTA events.

The Health Board is also represented at Gwent Citizens Panel, Torfaen Access Forum and works with third sector organisations, Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance.

The Health Board also runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services. In 2022/23, the Health Board spoke directly with over 4300 residents across 149 venues.

The Health Board is committed to working constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for the population of Gwent. This is delivered in accordance with the Health Board's statutory duties and any specific requirements or directions made by the Welsh

Ministers, which includes the development of population assessments and area plans.

Local Partnership Forum (Known as the Trade Union Partnership Forum [TUPF])

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year and the Board receives an Annual Report on the work of the Forum.

Healthcare Professionals' Forum (HPF)

The purpose of the HPF is to facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making.

During 2022/23, the Board did not have in place its Healthcare Professionals Forum. In the absence of this Group, the Board has continued to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups, such as the Clinical Directors Forum and System Leadership Group. The Board also engages with primary care providers through its cluster arrangements. It is the intention to take forward arrangements in respect of the Healthcare Professional's Forum in 2023/24.

Joint Committees

As set out within the Health Board's Standing Orders, the Board is required to establish, as a minimum, the following joint Committees:

- The Welsh Health Specialised Services Committee (WHSSC) and
- The Emergency Ambulance Services Committee.

Welsh Health Specialised Services Committee (WHSSC)

The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards in Wales.

WHSSC was established in 2010 by the Local Health Boards (LHBs) in Wales to ensure that the population of Wales has fair and equitable access to the

full range of specialised services. In establishing WHSSC to work on their behalf, the seven LHBs recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

WHSSC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the Joint Committee's activity are regularly reported to the Board.

Further detail in respect of Welsh Health Specialised Services Committee can be found on WHSSC's website

Emergency Ambulance Services Committee (EASC)

Emergency Ambulance Services in Wales are provided the Welsh Ambulance Services NHS Trust (WAST) and commissioning of Ambulance Services in Wales is a collaborative process underpinned by a quality and delivery framework. The framework provides for clear accountability for the provision of emergency ambulance services with the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of Health Boards and holding WAST to account as the provider of emergency ambulance services. EASC is hosted by Cwm Taf Morgannwg University Local Health Board. The Health Board is represented on the Committee by the Chief Executive and reports of the joint committee's activity are regularly reported to the Board.

Further detail in respect of Emergency Ambulance Services Committee can be found on EASC's website.

STATUTORY & STRATEGIC PARTNERSHIPS

Gwent Regional Partnership Board

The Gwent Regional Partnership Board (RPB) is established under Part 9 Social Services and (Wales) Wellbeing Act 2014 and the Partnership Arrangements (Wales) Regulations 2015, within which local authorities and local health boards are required to establish Regional Partnership Boards to manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services, and care and support is in place to best meet the needs of their respective population. The objectives of the Gwent Regional Partnership Board are to ensure the partnership bodies work effectively together to:

- Respond to the population assessment carried out in accordance with section 14 of the Act;
- Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act;

- Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and
- Promote the establishment of pooled funds where appropriate.

Welsh Government has distributed a Health and Social Care Regional Integration Fund across Wales to the seven Regional Partnership Boards (RPBs) in Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board are:
- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracey Daszkiewicz, Executive Director for Public Health & Strategic Partnerships
- Hannah Evans, Executive Director of Strategy, Planning & Partnerships
- Phil Robson, Special Advisor to Health Board
- Katija Dew, Independent Member

Further detail in respect of the Gwent RPB can be found on the RPB's website.

Gwent Public Services Board

The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:
- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive

- Tracey Daszkiewicz, Executive Director for Public Health & Strategic Partnerships

Further detail in respect of the Gwent PSB can be found on the PSB's website.

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and National Health Service Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's website.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

As Chief Executive and Accountable Officer, I have overall responsibility for risk management and report to the Board on the effectiveness of risk management across the Health Board. My advice to the Board has been informed by executive officers and feedback received from the Board's Committees, in particular the Audit, Risk and Assurance Committee and the Patient Quality, Safety and Outcomes Committee.

Executive Team meetings present an opportunity for executive directors to consider, evaluate and address risk, and actively engage with and report to the Board and its committees on the organisation's risk profile. The Health Board's lead for risk is the Director of Corporate Governance, who is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Depending on the nature of risk, other Directors will take ownership for management and mitigation, for example, patient safety risks fall within the responsibility of the Medical Director, the Director of Nursing and Midwifery and the Director of Therapies and Health Science.

The Risk Management Framework

The Health Board revised its approach to risk management in 2021 which resulted in a substantial revision of the Risk Management Strategy. This approach is a hybrid model of best practice risk management frameworks including COSO Enterprise Risk Management Framework, ISO 31000 and usual Health systems risk management approaches.

To further support this, a risk management strategy benefits realisation plan was presented to the Audit, Risk and Assurance Committee in April 2022, which mapped the objectives highlighted in the Risk Management Strategy with progress updates and clarity on how the Health Board will determine measurements of success. The Audit, Risk & Assurance Committee will remain responsible for monitoring implementation of the plan to ensure the organisation reaches its full potential in relation to the revised Risk Management Strategy. In monitoring the ongoing implementation, any risks to delivery or gaps in assurance can be identified with remedial actions agreed and implemented to mitigate and ensure the plan continues to progress.

At each Board meeting, the Health Board receives a Strategic Risk Report which provides a high-level account of all risks included on the Corporate Risk Register. This report is published in the public domain, ensuring transparency and openness around the strategic risks the Health Board has identified as potential impacts to achievement of the Board's strategic priorities. Members of the public and any other stakeholders have the opportunity to comment or raise queries on these risk reports, in-line with the Health Board Standing Orders.

The Health Board's electronic risk management system and associated functionality provides a useful mechanism for operational teams to record risks, raise and escalate risks to a Strategic level via an alert to the Corporate Risk Register and subsequently the Head of Corporate Services, Risk and Assurance. In addition to this, the Executive Directors of the Health Board hold assurance meetings with their respective Divisions to discuss management of ongoing risks that Divisions hold and provides a further opportunity to escalate risks. Regular engagement with Executive risk owners is undertaken to update risks and ensure scoring remains consistent and balanced.

The Head of Corporate Services, Risk and Assurance provides a strategic risk report to each Committee of the Board and each report includes detailed risk assessments for the risks for which the Committee has been delegated responsibility to seek assurance.

In relation to Quality, Patient Safety risks, the Health Board has a well-established Quality Patient Safety Operational Group that reports to the Board's Patient Quality Safety and Outcomes Committee. This meeting is chaired by the Director of Therapies and Health Science and extends its membership to other clinical Executive colleagues.

The Health Board has a well-established a Risk Management Community of Practice (CoP). Representation has grown consistently, and the CoP continues to meet every other month. Topics at the CoP include risk appetite and tolerances, business continuity planning, regular updates on the strategic risks reported to the Board and its Committees alongside an 'open' section for staff to share areas of good practice and wider organisational learning on risk management or organisational maturity.

Board Assurance Framework

The Board Assurance Framework provides the Board with an overview of the Principal Risks to achievement of its Strategic Objectives, along with a position on the level of assurance that it can reasonably take in relation to each risk.

In June 2022, the Audit, Risk and Assurance Committee received an Internal Audit review of the Board Assurance Framework (BAF) in place during 2021/22. This review provided the Board with a reasonable level of assurance, although actions for improvement were identified.

In August 2022, the Audit, Risk and Assurance Committee received a presentation from the Director of Corporate Governance that outlined an updated approach to development of the BAF allowing for closer alignment and reporting with the Corporate Risk Register. The Committee considered the current position and recognised that further work was required to provide greater clarity, ownership and understanding of the BAF and its processes. The need for synergy to be developed between the BAF and the Corporate Risk Register as well as introducing processes to enable a greater

level of assurance across the breadth of the internal control system at an operational level was acknowledged.

At its meeting in March 2023, the Board received the first iteration of an integrated risk and assurance report, complete with assurance mapping and action plans identified to address gaps in assurances. Further development of the presentation of the report is expected to align with a rationalisation of the current strategic risks and a revised Risk Management Strategy. This is expected to be presented to the Board in Quarter 2 of 2023/24.

The Health Board's Risk Profile

As at end of March 2023, there were **25** strategic risks described within the Corporate Risk Register which represent the most significant risks to the Health Board in potentially impacting the delivery of the Board's strategic priorities.

High	**18**
Moderate	**7**
Low	**0**

A copy of the latest Strategic Risk Report presented to Board in March 2023 is available here. The risks contained within this have been subject to Executive risk owner scrutiny, challenge, and review. Robust assessments of the Health Board's internal control system were also undertaken, alongside a review of all sources of assurance related to each risk. Based on a calculation of averages methodology, an initial indication on each risk was given a RAG rated assurance level. This was in line with Internal Audit methodology when determining assurance levels for audit reviews.

An over-arching, high-level indication of the level of assurance the Board could derive from this iteration of the strategic risk report is set out below:

Nil	Satisfactory	Considerable
	X	

This means that the Board could take an overall level of ***satisfactory*** assurance that the strategic risks which comprise the Corporate Risk Register (at March 2023), and which represent significant risks to non-delivery of the IMTP, are being managed effectively. The Board could also take assurance that the system of internal control to manage these risks is deemed to be ***satisfactory***.

In April 2023, the Executive Team commenced work to undertake an in-depth review of the Corporate Risk Register, ensuring risks are appropriately articulated, scored and moderated. This work will be presented to the Board in Quarter 2, 2023/24.

Risk Appetite

The Board's Risk Appetite Statement is contained within its Risk Management Strategy. As part of its risk management arrangements, the Health Board has agreed a set of definitions in relation to risk appetite and attitude which is outlined in the table below. The risk ***Appetite*** can be applied to shorter term risks and can be more dynamic; however, the risk ***Attitude*** is usually applied to longer term risks and tends to be more fixed. It is noted, however, that the risk Appetite and Attitude definitions will be reviewed in order for the Health Board to progress its organisational approach to risk management.

Assessment	Description of potential effect
Very High ('hungry' for risk) Risk Appetite Level 5	The Health Board accepts and tolerates some risks because of the potential short and long term benefits that might arise. However, it recognises that this might result in reputational damage, financial impact or exposure, major breakdown in services, information systems or integrity problems, significant incidents of regulatory and/or legislative compliance issues, potential impact on staff/service users.
High (open to risk) Risk Appetite Level 4	The Health Board is willing to Tolerate or Treat risks that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users. This level of appetite is predicated on the benefits being anticipated to be significantly advantageous to the Health Board.
Moderate (cautious risk taking) Risk Appetite Level 3	The Health Board is willing to Treat, Tolerate, Transfer (upon a balance of residual risks) risks in certain circumstances that may result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.
Low (averse to risk) Risk Appetite Level 2	The Health Board aspires to Treat, Transfer or Terminate (except in very exceptional circumstances) risks that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or

Assessment	Description of potential effect
	legislative compliance, potential risk of injury to staff/service users.
Zero (avoid taking risks) Risk Appetite Level 1	The Health Board aspires to Terminate risks under any circumstances that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users or public.

Changes to standard reporting templates has enabled the Board to become more aware of risk appetite in relation to the risk profiles it is responsible for. The revised template for cover reports for Committees and the Board provides a high-level overview of the risks being managed within the Committee or Board's portfolio and whether they are being managed within the agreed risk appetite level, and where risks are not managed within agreed limits, that robust plans and objectives are in place to de-escalate.

In April 2023, the Board commenced developmental work to review and redesign its risk appetite against key business domains or 'themes'. These themes were derived from feedback received from the Board on the most significant risks to the Health Board in achieving its strategic objectives. The next stage of development of this work will be the translation of the clearly defined risk appetite levels related to specific risk areas, into clearly articulated risk scores. This will enable operational colleagues to apply the risk appetite levels directly to their service areas and promotes the consistency of approach from 'Ward to Board'. This approach will be described in a revised Health Board Risk Management Strategy to be finalised in Quarter 2, 2023/24.

Risk & Assurance Related Internal Audit Reviews

Over the last financial year, the Audit, Risk and Assurance Committee received reasonable assurance ratings for internal audit reviews undertaken on the BAF and in relation to Risk Management.

Corporate Governance, Board Assurance Framework

In July 2022, the Audit, Risk and Assurance Committee received the internal audit review on the BAF, providing a reasonable level of assurance. The purpose of the review was to "*evaluate the BAF process and supporting arrangements that are embedded within Aneurin Bevan University Health Board governance structure*." The report concluded a reasonable level of assurance could be taken and made 4 recommendations (2 medium, 2 low) to further develop, embed and strengthen the BAF to ensure Board and Committee business focused on the areas of weakest assurance and highest risk. The Health Board is pleased to report that progress against the

recommendations prompted by the internal audit review is in development with revised deadlines or have been completed.

Risk Management

In April 2023, the Audit, Risk and Assurance Committee received an internal audit review on Risk Management, providing a reasonable level of assurance. The purpose of the review was to provide the Board with assurance that appropriate risk management arrangements are in place within the Divisions (at an operational level).

The report made 4 recommendations, 2 medium and 2 low to strengthen risk management arrangements. These actions will be progressed in 2023/24, alongside further development of the organisation's risk management arrangements.

Financial Recovery Governance Arrangements

At Month 06, 2022/23, the Health Board reported a year-to-date position of £22.785m deficit, with a forecast year-end out-turn of £37m deficit. Further detail in respect of this reported financial position included in the Financial Performance Report, with an updated position at Month 07, 2022/23, presented to Board in November 2022.

In assessing the forecast position, the Executive Team undertook a range of deep dives into the financial position, with the key opportunities to reduce the forecast identified as the priority focus of a recovery programme for the remaining six months of the financial year. The focus of recovery was to progress a twin track approach to deliver short term opportunities for financial cost reduction as well as continuing to progress transformational opportunities for long term sustainability. This recovery programme was expected to deliver opportunities to ensure the forecast deficit of £37M was not exceeded, and to wherever possible, reduce the forecast deficit position from the forecast position.

As a consequence, a CEO accountability letter was sent to the Director General for NHS Wales to accompany the WG monthly monitoring return on the 13th October 2022.

In view of the forecast position, and the level of associated risk, the Board resolved to reserve for itself the oversight, monitoring and scrutiny of financial recovery for the remainder of the 2022/23 financial year. In doing so, the Board agreed to:

- Approve and oversee delivery of the financial recovery programme and financial risk mitigation plans which capture all of the actions, the governance arrangements and sets out overarching delivery plans for each of the financial recovery workstreams;

- Ensure a clear understanding of the financial risk relating to the financial recovery programme. The Board will review the financial risk on a monthly basis, based on actual financial performance;
- Receive assurance from identified Executive Leads that robust financial recovery workstreams are in place, effective management of risks and delivery of agreed actions;
- Where forecast financial delivery falls short of target and does not adequately mitigate risk, the Board will agree the approach to identifying the further schemes necessary to resolve the gap, including the review and approval of any additional cost reduction and cost avoidance measures.
- Consider the Health Board's capacity and capability to deliver financial recovery actions and consider proposals to address where necessary;
- Consider lessons learnt and ensure that these are reflected in future planning and delivery mechanisms.

In respect of financial management and financial performance, the Board requested that the Finance and Performance Committee dedicate a focus to financial planning for 2023/24, and in particular to seek assurance on actions underway to develop a robust medium-term financial plan for inclusion in the Board's Integrated Medium-Term Plan 2023-26.

The Executive Committee established a Financial Recovery Programme Board, which met formally each month (aligned to the financial reporting timetable) to ensure robust monitoring and tracking, in addition to weekly updates on progress and risks. In doing so, the Financial Recovery Programme Board:

- Developed, for Board approval, the financial recovery programme and financial risk mitigation plans which capture all of the actions, the governance arrangements and sets out overarching delivery plans for each of the financial recovery workstreams;
- Determined a standardised financial performance template to ensure consistent and appropriate information reporting to the Board, based on the agreed financial recovery programme;
- Assessed and monitor the financial risk relating to the financial recovery programme, based on actual financial performance, and consider mitigation actions required;
- Received updates and proposals from identified Executive Leads that robust financial recovery workstreams are in place, effective management of risks and delivery of agreed actions;
- Where forecast financial delivery fell short of target and did not adequately mitigate risk, consider, for the Board's agreement, the approach to identifying the further schemes necessary to resolve the gap, including the review and approval of any additional cost reduction, cost avoidance measures.

The Financial Recovery Programme Board also dedicated focus to financial planning for 2023/24 and the medium-term financial plan.

The Financial Statements, Section 3, provides greater detail on the financial performance of the Health Board in 2022/23.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements and supporting documents and submitted an annual report setting out the level of compliance in meeting the requirements for 2022.

THE CONTROL FRAMEWORK

Patient Safety, Quality and Experience

The Health and Social Care (Quality and Engagement) (Wales) Act 2020, places more responsibility on Health and Care organisations in Wales. Enhancing quality, honesty and transparency, the legislation that came into force in April 2023 provides the Health Board with a Duty of Quality and Duty of Candour. It establishes a Citizen Voice- LLais, which enriches engagement with our patients and community members. Llais is an independent body and its free Advocacy service can provide information, advice and support to members of the public.

The **Duty of Candour** is a legal requirement for NHS Organisations in Wales to be open and honest with patients who are receiving care and treatment. Through this Duty, the Health Board must be honest in informing patients and their families if the care provided has, or may have contributed to unexpected or unintended moderate or severe harm, or death. They need to know what happened and, to what can be done to ensure this does not happen again. A culture of openness, transparency and candour is widely associated with good quality care. This must encourage learning and be achieved without apportion of blame.

The **Duty of Quality** requires the Health Board to develop leadership and management systems with a view to securing improvement in the quality of services. Through continuous improvement of services over time, ensuring that quality challenges are improved upon. Reporting learning through annual quality reports. There are 12 Health and Care Quality Standards that will help us to describe what good quality care looks like in our individual services.

The Health Board understands the importance of providing high quality, safe, and compassionate care of the services it provides and commissions. However, we also recognise that in a complex environment, incidents may occur despite our best intentions. It is crucial that we are aware of the significance of our actions and our response in handling these situations. Being open and honest can have a major positive impact on the experiences of our patients, staff, carers and families, supporting their understanding when something has gone wrong and ultimately on their continued trust in the healthcare system.

The Health Board has approved its Quality Strategy which has been implemented throughout Aneurin Bevan University Health Board since April 2023. Our aim is to continuously improve and learn, new legislative requirements support the development of our strategy. Progressing on what we have already accomplished and building on existing structures throughout the organisation is a key focus in the development of this Strategy.

Quality is embedded in our culture, and we are committed to continually improving. Delivering high-quality healthcare to our local communities while putting Quality, Safety, Experience and Learning at the heart of everything we do.

The Health Board will adopt, at scale, the 'Care Aims' model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value and choice. This will provide us with improved metrics for patience experience and evidence of feedback influencing service plans, delivery and improvement. Through continuous improvement of our services over time, ensuring that quality challenges are improved upon, we will report our learning through our annual quality report.

We pledge to deliver the Duty of Quality by ensuring our services provide the highest quality of care for our patients, carers and families. We are committed to improving the experience of care and will seek

opportunities to provide positive patient experiences through the patient journey across our services. Our vision is quality-driven, and we will ensure data will drive improvement and learning through experience. We will develop and deliver our services around the domains of quality and quality enablers:

The six domains of quality and six quality enablers

The six domains of quality	Quality Enablers
Person-centred care	Leadership
Safe care	Culture
Timely care	Workforce
Efficient care	Information
Effective care	Whole systems approach
Equitable care	Learning, improvement and research

The Quality vision of Aneurin Bevan University Hospital Board is to be "widely recognised for delivering the Health and Care Quality Standards". Our first and most important commitment to our patients is to keep them safe. Over the next three years, this Quality Strategy will improve the delivery within these Quality Standards, while continuing to improve patient and staff experience and outcomes.

The experiences of our staff and patients will continue to be the most important measure of our progress. It is the delivery of this Strategy, together with the supporting strategies of patient experience and involvement, risk management, clinical effectiveness and employee wellbeing to deliver high quality care, person centred and effective health and care services for our local population.

To achieve Our Quality Strategy will require a strong commitment to undertake a Health Board wide culture change, where patients are informed and educated about our services to meet their needs, guaranteeing equitable access to services. Our organisation has a solid foundation on which to build, and we will improve by listening, learning and working together on a continuous improvement journey.

We aim to create a strategy that can be used as a charter to empower people to live good lives and prevent harm. We will create a culture where staff feel listened to, based on transparency, accountability, ethical behaviour, trust and a 'Just Culture'. We will continue to actively listen to our service users and respond to make it a good experience for all.

By developing this Quality Strategy, we are making clear our commitment and approach to empowering the people at the heart of our services. Staff will have the freedom, skills, tools and resources to work in partnership with the people we serve to improve and innovate safely towards defined quality goals.

We remain committed as an organisation to becoming a true learning organisation. We will focus on delivering the highest possible quality care, meeting the health and care needs of people using our services, and improving the health outcomes of the population we serve. This strategy highlights our creativity, passion, expertise and our commitment to learn from experiences. Our quality pledge and ambitions aim to put quality, equality and learning at the heart of our service.

We will become a learning organisation by:

- Ensuring we are doing everything we can to make *everyone's* health and care experience the best it can be, delivering safe and effective services.
- Ensuring our colleagues are valued, work in safe and secure environments, and are supported and empowered to act when things can be improved.
- Ensuring the people, we serve are heard, included, involved and empowered;
- We will embrace transparency, accountability and knowledge, celebrate success, share learning and actively seek to improve.

We aim to become a true learning organisation to improve patient safety, experience and clinical effectiveness. We will respond to learning and guidance from our Quality Management System, local and national groups, adapting our plans and priorities to ensure we are doing the right things.
The key to delivery of our plans is to develop a 'Quality Management System' approach to embed a culture of learning: a culture where people listen, think, feel and act 'quality' - promoting openness and learning, continuous improvement and service transformation. This includes work to embed positive cultures of continuous improvement and working together. We will further develop our Quality Management System to routinely set meaningful targets and, monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.

Our quality goals are called 'pillars of quality', which run through our Health Board, ensuring that we deliver the highest standards of care under these domains. We will review our performance by providing data in these Pillars of Quality, and we must prioritise the quality and safety of our health services above all else. This strategy signals our intention to progress these pillars of quality to baseline and benchmark our level of performance. The pillars will also be our Quality Markers in our Quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.
Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security

- Infection Control and Prevention
- Safeguarding

Our strategic goals are to develop and empower our workforce to deliver outstanding care. Our staff and services are eager to learn, working together with families and experts by experience to improve services. We aim to enable our workforce to be happy, confident and competent. We will empower our workforce to deliver outstanding care by supporting the professional development of colleagues, giving them the mandate, tools and resources to innovate and improve. We will develop a 'Just Culture' which promotes safety through supporting people to speak up. We will encourage staff to be more open and transparent about incidents, errors or complaints and the actions we take to make changes.

We will measure our progress and guide our actions towards becoming a learning organisation. We will grow and mature our Quality Improvement approach as our methodology for solving complex problems, and to provide a consistent approach to testing change ideas and informing our decisions.

In order, to drive and improve the quality of care delivered across our communities the Health Board will increasingly rely on partnerships across our communities. We will further develop our role as part of an integrated Health Board, working more closely with our commissioners and with other local providers, including Primary Care, the Independent Sector, Charities and colleagues in Social Care. Positioning quality throughout our organisational structure is important in integrating communication from Ward/ Teams to Board.

As part of the Health Board's Quality Strategy, a Quality Assurance Framework is being developed to form an essential element of the overall system. The purpose is to mitigate and manage risk associated with achieving our strategic objectives and priorities as outlined in the Health Board's Integrated Medium-Term Plan (IMTP). The Framework is aligned to the Board's Assurance Framework and has inherent links to the Risk Management Strategy.

The Quality Assurance Framework Structure of the Health Board is made up of a range of groups, each of which focuses on a different aspect of quality, patient safety and experience and ultimately reports to the Health Board's Patient, Quality Safety Outcomes Committee (PQSOC), via the Quality and Patient Safety Operational Group (QPSOG). The Health Board is reviewing QPSOG as part of our Quality Strategy implementation, with the goal of refocusing the QPS governance framework.

Information Governance

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Information Governance is about setting high standards for handling this information and giving the organisation the tools to achieve those standards.

The Health Board has a range of key roles that have responsibilities in relation to the information that it holds, uses and shares. The Medical Director is the Caldicott Guardian, the Director of Corporate Governance is the Senior Information Risk Owner (SIRO) and the Head of Information Governance is the Data Protection Officer (DPO).

During 2022/2023 the Health Board continued to develop the forums for the organisation to consider information governance requirements and to provide a consistent way in which it is managed. These forums allow the facilitation of processes and communications which ensures that all Data Protection obligations are met. Dashboards are produced to provide support and assistance ensuring compliance with training, dealing with complaints, incident and breach management. Annual reports are produced on progress made throughout the year and disseminated to the relevant divisions and boards.

The Health Board continues to be proactive in using the NHS Wales IG Toolkit to ensure consistency of policy, standards and interpretation of the law and regulation across NHS Wales organisations. The Health Board achieved a score of 95% for the last year.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is embedded in the way in which the Health Board shares relevant information with its partner organisations.

During 2022/2023 there was a 10% increase in the number of Subject Access Requests (SARs) compared to the previous year. The largest proportion of requests received continues to be made by solicitors and legal services.

During this year there was a 31% decrease in IG incidents reported by staff from the previous year.

There were 6 complaints made to the Information Commissioners Office (ICO) by complainants, with 5 not upheld and one awaiting a final outcome.

In 2022/23, there were no serious lapses in data security reported to the ICO by the Health Board, with the exception of an incident involving a cyber-attack to the Adastra system. This incident was reported to the ICO byall Health Boards, however no data relating to ABUHB patients was compromised.

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self-assessment against the code is provided as **Attachment Three**.

PLANNING ARRANGEMENTS

The NHS Wales Finance Act 2006 requires the submission to Welsh Government of Integrated Medium-Term Plans (IMTP) for approval.

At its meeting in March 2022, the Board approved its IMTP for 2022-25 for submission to Welsh Government. The Health Board's Integrated Medium-Term Plan 2022-25 was a natural progression from the Annual Plan 2021/22, building on the life course approach, whilst recognising the context within which the Health Board operated was different from the one recognised in 2020/21. This being a renewed focus on sustainable recovery, characterised by a fundamental shift that encompasses the wider role of Health and Social Care in reducing health inequalities, delivering the foundational economy, and protecting the environment for future generations with the Net Zero 2030 ambition.

On 22 July 2022, the Health Board received written confirmation that the Minister for Health and Social Services had approved Aneurin Bevan University Health Board's IMTP 2022-25.

On 28 November 2022, the Minister for Health and Social Services issued the NHS Wales Planning Framework for the 2023/2024– 2025/2026 planning cycle.

The Health Board's IMTP 2023/26, together with supporting templates and appendices, was approved by the Board in its meeting on the 29th of March 2023. The submission recognised the significant challenges and risks going forward and the financial context within which we are operating to deliver the plan. The Duty of Quality and Duty of Candour are at the forefront of the IMTP, alongside the need to drive efficient and effective service delivery.

The IMTP maintained a three-year focus given the emphasis on long term sustainability but with a greater level of detail on year one (2023/24) delivery given the scale of challenge and ministerial expectations.

Following submission, a response was received from Welsh Government on 21st April 2023, noting that the Health Board's IMTP did not satisfy its statutory duties under the NHS Finance (Wales) Act 2014, nor did it deliver on all of the requirements as set out in the Ministerial Priorities. Consequently, Welsh Government was unable to put the submitted IMTP plan forward for the full internal "collective review" process.

Welsh Government requested that the Health Board undertook further work setting out an improvement in the position on delivery of Ministerial priorities, and an improvement in the financial assessment by 31st May.

In response to the feedback, the Health Board undertook detailed work to test opportunities to make improvements to delivery commitments.

The Health Board considered the financial plan and forecast to be the most appropriate assessment based on the current information available and recognising the ambition and consideration of risk to achievement.

The Health Board re-submitted its IMTP to Welsh Government following approval by the Board on 24th May 2023, the outcome of which is awaited. Therefore, at the time of writing this report, the Health Board does not have an approved IMTP for the three-year period 2023/26.

MANDATORY DISCLOSURE STATEMENTS

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2022/23 Financial Statements (Note 20).

Equality, Diversity & Human Rights

The Health Board is required to consider all individuals in their day-to-day work, in shaping policy and in providing services. This is in line with the Public Sector Equality Duty (PSED) introduced by the Equality Act 2010.

The Health Board's Strategic Equality Plan sets out our ambitions for equality, diversity and inclusion (ED&I) between 2020 and 2024, both in relation to staff and in providing services to the public. This strategy ensures that, as a Health Board we continue to champion ED&I in all that we do, whether it concerns our staff, patients or the wider public.

The Strategic Equality Objectives for 2020 – 2024, have been integrated into the Health Board's IMTP and People Plan, adopting a mainstreaming approach, by embedding ED&I into our plans, processes, values and behaviours.

A refreshed Strategic Equality Plan will be published in 2024.

The Health Board's Annual Equality Report outlines the work that was undertaken from 01 April 2022 - 31 March 2023 to meet our Strategic Equality Objectives. We also have duties to publish information about our workforce and how we use this data and this report includes the Equality Monitoring data based on a snapshot as of 31 March 2022.

We annually publish information on our Gender Pay Gap. The Health Board has also made a commitment as a result of the Welsh Government's Anti-Racist Action plan, to provide a report to describe the potential pay gap experienced by Black, Asian and Minority Ethnic staff. This report provides an initial baseline assessment, identifies any pay gaps and will enable the development of an action plan to address any ethnicity pay gaps over the coming years.

In addition to our annual reporting cycle, governance arrangements for ED&I ensure the board of directors receive regular assurance that the Health Board is meeting its Public Sector Equality Duty (PSED) requirements.

In line with the recommendations of the Equality Impact Assessments: More than a Tick Box Exercise? Report of the Auditor General for Wales, 2022, we are currently reviewing our current Equality Impact Assessment (EqIA) process to support meaningful equality analysis; ensuring that we identify where a policy, procedural document, service, service developments or organisational change may have a negative impact on individuals or groups of people with protected characteristics under the Equality Act and robust action plans are developed to address these potential impacts. It is anticipated that this will be completed by September 2023.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

A coherent Strategic Equality Plan (SEP) and Equality, Diversity and Inclusion Policy have been developed to ensure that working practices across the organisation support an inclusive culture which embraces difference. These are supported by organisational values and leader and

manager behaviour which reflect the importance of EDI and are routinely reviewed through checks, audits and consultation.

A substantial review of the health boards equality objectives and SEP is currently underway. The equality and human rights policy framework is in place supported by a programme of training to raise awareness and build capacity in regards to the Public Sector Equality Duty (PSED) and to support staff to deliver on their responsibilities.

Other measures include:

- The Health Board has an Executive Lead for Equality, Diversity and Inclusion
- Equality development sessions facilitated for Board to ensure they are aware of their duty to have 'due regard' to the PSED
- Equality considerations are captured in the governance table on all Board and committee papers requiring a decision
- The Annual Equality Report demonstrates how the Health Board meets the duties associated equality and human rights and the arrangements for equality impact assessment (EqIA)
- Opportunities are being identified to build delivery of the SEP into planning and service delivery mechanisms and the system for improvement
- The Health Board's People Plan is informed by workforce equality information and EqIA
- Equality and Human Rights Training is mandatory for all staff
- Scrutiny of EqIA has been strengthened this year
- Risks associated with compliance will be identified and be included in the corporate risk register
- The Race Advisory Group monitors compliance against the Anti-Racist Wales Plan
- The LGBTQ+ Advisory Group monitors compliance against the LGBTQ+ Action Plan
- The Health Board has continued to build on existing relationships and establish new ones with community groups and partners. There is regular engagement with the Diverse Communities Health Forum. This Forum includes representation from members of the public with an interest in equality issues
- The Equality Annual Report is submitted to Board via the People and Culture Committee governance route; published and accessible to the public

Counter Fraud, anti-corruption and anti-bribery matters.

Aneurin Bevan University Health Board is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic

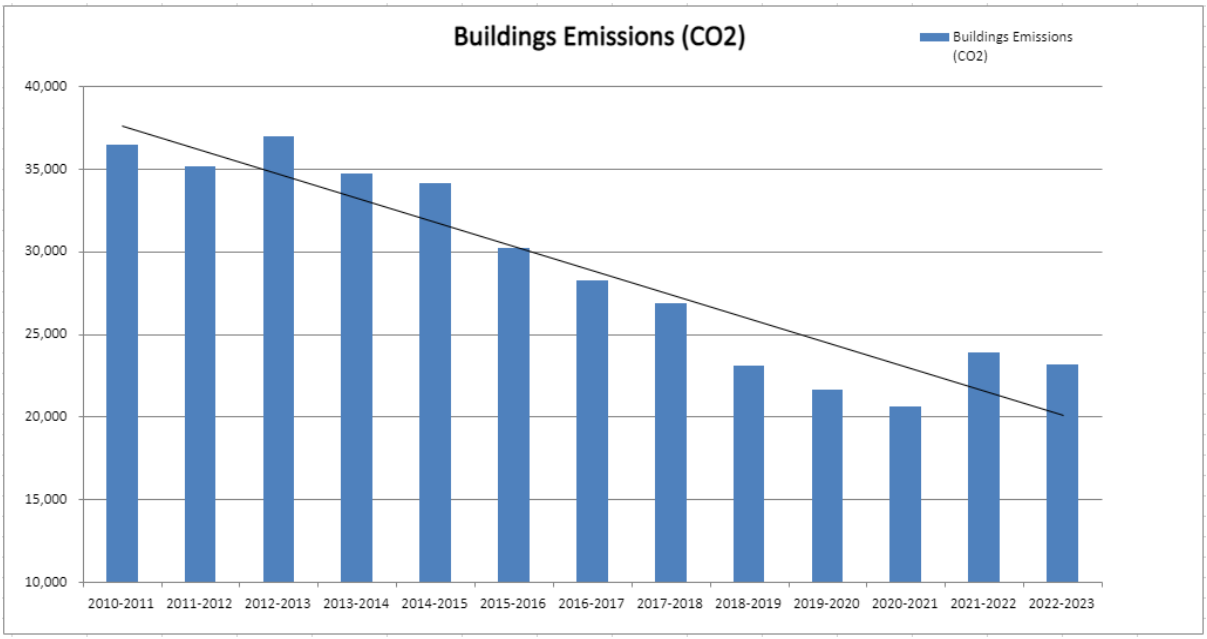
crime. Further information on the valuable work undertaken is available in the Counter Fraud bribery and Corruption Report 2022/23.

Sustainability and Carbon Reduction Plans

The Health Board continues to align its activities to complement and make progress towards the objectives and targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan, published by Welsh Government in 2021. The Plan responds to the declaration of the climate emergency in 2019 and the ambition of Welsh Ministers for the Welsh public sector to be net zero by 2030. During 2022/23 the Health Board established its Decarbonisation Programme Board, chaired by the Executive Director for Finance and Procurement. Four working groups have been set up, each sub-group having a number of the national initiatives assigned to them to take forward and develop associated projects. In 2023/24, the Health Board will establish its Decarbonisation Framework in response to the national plan.

In the last decade the Health Board has made consistent progress with reducing both energy consumption and carbon emissions from its estate. With the opening of the Grange University Hospital in November 2020, a new building emission baseline has been set using full year 2021/22 data.

Between 2009/10 and 2021/22 the emissions from energy use in buildings was cut by 37%, equating to a saving of 14,161 tonnes of carbon. Naturally with the opening of GUH the Health Board's carbon emissions have increased. Positively, during 2022/23 efficiencies have been implemented and a year-on-year carbon saving of 3.1% has been realised.



The Health Board is currently finalising tender specifications for the ReFit Cymru Energy Performance Contract. A Welsh Government endorsed

framework where the Health Board will partner with a service provider to design and implement large scale decarbonisation projects across the estate over the coming years; with an emphasis on renewable and low-carbon technologies. Where the service provider financially guarantees energy revenue savings as part of the contract.

The Health Board continues to work towards introducing more sustainable and resource efficient methods of processing waste generated from health care activities. The Health Board has now implemented a zero-waste to landfill approach, in collaboration with external contractors. Waste now goes to energy-from-waste plants to generate sustainable electricity.

The Health Board continues to operate a third party certified Environmental Management System (EMS) to the international standard ISO 14001:2015. The EMS has been developed to become the focal point for driving forward continual environmental and sustainability improvements. It provides a joined-up approach for the management of waste minimisation initiatives, recycling, energy and carbon management, sustainable procurement and sustainable travel initiatives. The Health Board places high importance on continued certification to ISO14001:2015 and the assurance it provides to the Board and our stakeholders.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the estate. To this end, a number of local initiatives are in place including wildflower planting in conjunction with external art installations at the Grange University Hospital, the continued success and development of the Walled Garden at Llanfrechfa Grange by the charitable organisation 'Friends of Llanfrechfa Grange Walled Garden'.

Biodiversity studies have been completed on 5 of the Health Board sites after securing funding from the health and social care climate emergency national programme in 2022/23. These studies will be used to inform future biodiversity opportunities that are presented going forward on these specific sites.

The second funding stream was secured from the HSCCENP as mentioned above for a Clinical Fellow in Sustainability to deliver the Desflurane gas eradication project across the ABUHB and was completed in December 2022. ABUHB was the first Health Board to completely remove this gas from operation.

Further work to support the Nitrous Oxide scavenging process is planned during the 1st and 2nd quarter of 2023.

The Health Board's Annual Sustainability Report is available on the following link.

The Health Board is unable to confirm compliance with the following statement:

The organisation has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the climate change Act and the Adaptation Reporting requirements are complied with.

The Health Board submits Continuity Plans through normal reporting frameworks. There is a commitment to look at this in 2023/24, with more work needed nationally to support this.

Quality of Data

The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial Directions issued to the Health Board in 2022/23 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2022/23 Financial Statements (Note 20).

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation.

During 2022/23, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. Work will continue in 2023/24 to strengthen the reporting of risks to the Board and its Committees. Approval of the Board's Quality Strategy in March 2023, and ongoing development of a Quality Assurance Framework, will ensure that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides the Chief Executive/Accountable Officer and the Board, via the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

During the year the Audit, Risk and Assurance Committee received Internal Audit reports in line with the agreed programme for 2021-22 and 2022-23, including the management response from the relevant Executive Director.

In total, 34 assurance-rated reviews and 7 advisory reports were reported to the Audit, Risk and Assurance Committee throughout 2022/2. Out of the 41 received 16 were from the 2021/22 Audit Plan. These are detailed in the assurance rating sections.

As at end May the Committee is still to receive the following final reports from the 2022-23 Internal Audit Plan. These are expected to be received during quarters 1 and 2 of the 2023-24 financial year.

- Putting Things Right
- Review of Bank Office & Temporary Staff

The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2022-23.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

The Grange University Hospital *(2021 -22)*
Executive Lead – Executive Director of Planning, Digital & IT
The review sought to provide assurance around Quality Assurance, focusing on an assessment of the delivery Grange University Hospital building against the key business case objectives.

Grange University Hospital: Financial Assurance *(2022-23)*
Executive Lead - Chief Executive
The overall objective was to determine the adequacy of information provided in support of the Stage 4 (construction) defined costs claimed by the Supply Chain Partner (through selective testing of the account)

Digital Benefits Realisation *(2022-23)*
Executive Lead - Chief Executive
The review sought to consider whether the organisation has an appropriate framework and process to ensure that benefits are gained from investment in digital solutions.

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Falls Management *(2021-22)*
Executive Lead – Executive Director of Therapies & Health Science
The review sought to provide assurance that the Falls Policy for Hospital Adult Inpatients was being adhered to by staff and monitored appropriately.

Flu Immunisation *(2021-22)*
Executive Lead - Executive Director of Public Health and Strategic Partnerships
The review sought to provide assurance that the flu immunisation programme in place for staff, and the governance arrangements over the community programme are working efficiently to provide maximum protection during the seasonal flu campaign.

Risk Management *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to provide an opinion on the effectiveness of the risk management arrangements in place within the Health Board to ensure strategic objectives are achieved.

Facilities - Care After Death *(2021-22)*
Executive Lead – Director of Operations
The review sought to provide assurance on the care after death service within the Facilities division, which commenced operations during January 2021.

Flow Centre *(2021-22)*
Executive Lead – Director of Operations
The review sought to assess the processes within the Flow Centre Team for ensuring patients are cared for in the right place, at the right time, ensuring

local coordination with other partners; and providing a single point of contact for transferring patients into and between hospital sites.

Corporate Governance *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to evaluate the Board and Risk Assurance Framework (B&RAF) process and supporting arrangements that are embedded within the Health Board governance structure.

Operational Resumption of Services *(2021-22)*
Executive Lead – Director of Operations
The review sought to evaluate the adequacy of the systems and controls in place for the operational resumption of services.

Financial Sustainability *(2021-22)*
Executive Lead – Director of Finance, Procurement & Value
The review sought to evaluate the key financial management controls within the Health Board, including developing and monitoring the savings required for financial sustainability.

Medicines Management *(2021-22)*
Executive Lead - Medical Director
The review sought to provide the Health Board with the assurance that there are adequate arrangements in place for the management, administration, and storage of controlled drugs.

NIS Directive (Cyber Security) *(2021-22)*
Executive Lead - Director of Planning, Digital and IT
The audit sought to review the arrangements in place for the implementation of the NIS (Network and Information Systems) Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Waste Management *(2021/22)*
Executive Lead – Director of Operations
The review sought to assess the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Children's Community Nursing Service – Children & Young People's Continuing Care *(2022-23)*
Executive Lead - Director of Operations
The review sought to assess the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Health Board's Children's Community Nursing Service (the CCNS, part of the Family & Therapies Division). With a focus on mechanisms for ensuring the quality and safety of the Children and Young People's Continuing Care provision.

Job Evaluation Process *(2022-23)*
Executive Lead - Director of Workforce & Organisational Development
The review sought to provide assurance that the Job Evaluation process meets the requirements of the NHS Job Evaluation Handbook and is being applied effectively by the Health Board.

It also sought to provide assurance that all posts that are banded through the job evaluation process are done so in a fair and consistent manner to ensure there is equality for all members of staff.

Neighbourhood Care Networks (NCNs) *(2022-23)*
Executive Lead – Interim Executive Director of Primary Care, Community & Mental Health
To provide an opinion on the effectiveness of the controls in place to improve access to primary care services through the NCNs.

Integrated Audit Plans – YYF Breast Care Services *(2022-23)*
Executive Lead: Director of Operations
The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit.

Integrated Audit Plans – Newport East *(2022-23)*
Executive Lead: - Interim Executive Director of Primary Care, Community & Mental Health
The audit was undertaken to review the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

Risk Management *(2022-23)*
Executive Lead: Director of Corporate Governance
The review sought to provide an opinion on the effectiveness of the risk management arrangements in place within a sample of Divisions. To determine the effectiveness key sections of the Risk Management Strategy and Framework (the 'Framework') were considered.

Financial Sustainability *(2022-23)*
Executive Lead: Director of Finance, Procurement & Value
The audit was undertaken to review the key financial management controls within the Health Board including the development and monitoring of savings programmes required for financial sustainability.

Monitoring Action Plans *(2022-23)*
Executive Lead: Director of Corporate Governance
To audit sought to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE).

Management of the Robotic Process Automation *(2022-23)*
Executive Lead: Chief Executive Officer
The purpose of the review was to ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

IT Strategy *(2022-23)*
Executive Lead: Chief Executive Officer
The purpose of the review was to ensure that the organisation has developed an appropriate target operating model to enable the delivery of the Digital Strategy.

Children and Young People's Continuing Care *(2021-22)*
Executive Lead – Director of Nursing
The purpose of the review was to ensure that the Mental Health and Learning Disabilities Division has robust commissioning arrangements in place, with a focus on quality and safety for the commissioning of Continuing Health Care (CHC) and Section 117 care.

Development of a Regional Radiotherapy Satellite Centre at Nevill Hall Hospital *(2022-23)*
Executive Lead: Executive Director Strategy, Planning and Partnerships
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives.

Development of a Regional Radiotherapy Satellite Centre at Nevill Hall Hospital
Executive Lead: Executive Director Strategy, Planning and Partnerships
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives.

Mental Health Transformation (2022-23)
Executive Lead: Chief Operating Officer
This audit was undertaken to provide a review of the controls in place for the projects that support the transformation of mental health services within the Health Board.

Dementia Services (2022-23)
Executive Lead: Director of Nursing
This audit examined the dementia services carried out by the Health Board, across a sample of wards.

Infection Prevention & Control (2022-23)
Executive Lead: Director of Nursing
The audit assessed the level of adherence to key policies and procedures throughout a sample of wards, regarding infection control.

Integrated Wellbeing Networks (2022-23)
Executive Lead: Chief Operating Officer
The audit sought to review the arrangements in place to improve and strengthen wellbeing within the community by utilising existing community assets

Contract Management(2022-23)
Executive Lead: Chief Operating Officer and Director of Finance & Procurement
This audit examined the operational management of a sample of contracts entered into by the Health Board. Initially, three contracts were sampled, but this was extended to five contracts, to further assess the embedding of processes within the Health Board

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

The Management response and action plan to respond to the issues and weaknesses identified, which form part of the final reports, are considered by the Audit, Risk and Assurance Committee. The Committee monitor progress in line with agreed timescales via the Audit Recommendations Tracker.

In addition for all limited assurance rated reports, executive leads attend the Audit, Risk and Assurance Committee to provide assurance on the actions identified.

Clinical Audit *(2022-23)*
Executive Lead – Medical Director
The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.

The following recommendations were raised:
- A Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review.
- There is no local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits

that should be completed may go unidentified, leading to additional clinical risks.
- There is limited tracking / monitoring of actions raised and the delivery of clinical audits.

A Clinical Audit Strategy was approved by the Patient Quality, Safety and Outcome Committee in August 2022 and work is underway to implement the clinical audit strategy and update the Health Board policy on clinical audit.

A robust structure is now in place underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided by reporting to the Patient Quality and Safety Outcomes Committee, providing scrutiny of National Clinical Audit performance with robust development and monitoring of improvement plans. The Clinical Audit Plan will be monitored by CSEG, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively. Actions and findings from national and local clinical audits will be monitored by this Group and will be utilised to inform future planning within the Health Board.

Working alongside Risk and Governance will ensure the appropriate governance structures and arrangements are in place for Clinical Audit. The development of a Risk Management Strategy and Board Assurance Framework will address how risks from Clinical Audit are escalated. This will provide assurance from each applicable divisions / directorate. This is being developed as part of the Quality Strategy and will be finalised in the next six months.

Corporate Governance (Policy Management) *(2022-23)*
Executive Lead – Director of Corporate Governance
The audit was undertaken to review the process for the management of policies throughout the Health Board.

The Audit concluded that, overall, there was an appropriate and up-to-date framework and guidance document for the management of policies in place. However, there were a significant number of policies and other documentation overdue for review (316 of 881 policies, 36%).

An overarching 12-month improvement plan is in place, with a focus on the policy framework, management systems, and the central database.

Use of off-contract Agency *(2022-23)*
Executive Lead – Director of Nursing
To assess whether off-contract agency processes are adhered to, and related expenditure is appropriately monitored.

The audit noted control design weaknesses in the processes in place to minimise the use of off-contract agency and in the substantive testing of a sample of shifts filled by off-contract agency nurses found instances of practices not conducive to the achievement of this objective.

Auditors also analysed the timeliness of actions set out within the process being completed e.g. the completion of a sample of rosters. The matters requiring management attention include: • Addressing policy/procedure expiry; • Lack of evidence that all other resource options have been exhausted before the approval of off contract agency use; • Establishing an end-to-end shift escalation timeline standard; and • Addressing bank and agency process anomalies

A new protocol had been implemented shortly after the audit's conclusion, which had resulted in a reduction in the use of off-contract agency.

The use of off-contract agencies has reduced as a result of a number of factors, including new booking rules for agencies, the variable pay reduction programme and subsequent recruitment events.

To continue to reduce the use of off-contract agency, the Director of Nursing and divisional nurses have agreed to work towards eradication of off-contract agency beginning 01 March 2023, with agreed targets and escalation processes in place.

Records Management *(2022-23)*
Executive Lead – Chief Executive Officer
The review sought to provide assurance that the Health Board has an appropriate process for the management of records which ensures that it is compliant with legislation.

Overall, the audit raised issues over the storage and security of records at some sites; the limited ability to track certain records, concerns over records management practice on some wards and the delays in the availability of records.

An action plan is in place to respond to the recommendations and significant progress had been made on both paper record storage and the digitisation project. ABUHB was the only Health Board to have digitised 0.5 million records. However, it is acknowledged that further work is required to improve record management across the Health Board.

Discharge Planning *(2022/23)*
Executive Lead: - Interim Executive Director of Primary Care, Community & Mental Health
This audit was undertaken to provide an opinion on the discharge planning process of the Health Board. It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted during April and May 2022.

The review found that discharge planning practices were not supported by the out-of-date Discharge Policy, there was no compliance audit programme and reporting. Furthermore, the evidential support of the discharge process was lacking, based on the results of the sample testing.

In addition, Internal Audit raised comments on the simple and complex pathways approach, the use of checklists, and improvement in the reporting, analyses and actions to address avoidable re-admissions.

An Action Plan is in place to address the recommendations. The Nurse Director has been identified as the executive lead for discharge and the Discharge Programme Board is now part of the Six Goals Programme.

Collaboration with local authority colleagues has been established to allow the Health Board to begin formally reporting the new Welsh Government data set that was required in relation to delayed discharge; however, the data required validation with LA colleagues.

Two pilots have been undertaken, one in Royal Gwent, in collaboration with Newport and Monmouthshire Social Services, focusing on repatriating patients back into the community, and another in Nevill Hall, exploring different ways for Community Resource Teams (CRT) to pull patients back into the community.

Tredegar Health & Wellbeing Centre *(2022-23)*
Executive Lead: - Interim Executive Director of Primary Care, Community & Mental Health
The audit sought to review the management and governance arrangements in place to progress the Bevan Health & Wellbeing Centre.

This assessment primarily recognised the significant delays in the delivery of the project (circa 30 weeks at the time of the review), and associated current cost pressures. Whilst the forecast at the time was for the project to be delivered £380k (2%) over the approved budget there remained further significant risks. These were not accommodated within the forecast outturn cost projections, and the associated delay in achieving the anticipated business case objectives. Whilst noting the same, it was acknowledged that the delays were not currently being attributed to Health Board actions.

Assurance at other areas, notably equipping, was reduced due to identified non-compliance with the Health Board's Standing Orders / Standing Financial Instructions and delegated authorised limits.

An action plan to respond to the recommendations is being implemented, noting that the project delays were due to foundation design and brickwork.

No Assurance

There were no audited areas that reported **no assurance.**

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Datix (Support of Incident Management) *(2021-22)*
Executive Lead – N/A
The review sought to provide the Health Board with an overview of testing completed within other audits that a sample of incidents entered onto Datix are being managed appropriately and in accordance with the Incident Reporting Policy.

Follow-up of High Priority Recommendations *(2021-22)*
Executive Lead – Director of Corporate Governance
The review sought to determine if a sample of high priority recommendations had been implemented or recognised as still outstanding on the Audit Recommendation Tracking Tool.

Medical Equipment and Devices *(2021-22)*
Executive Lead – Medical Director & Director of Therapies & Health Science
The audit assessed the maintenance of the electronic medical devices and equipment (EBME) database and the management of other medical equipment/devices and associated training requirements. The audit objectives were consistent with the 2017/18 Medical Equipment and Devices audit (rated 'limited assurance'), which enabled a high-level review of progress to be completed.

Agile Delivery *(2022-23)*
Executive Lead- Director of Workforce & Organisational Development
The review sought to assess the Health Board's progress in developing agile working practices and identification of good practice.

Decarbonisation *(2022-23)*
Executive Lead – N/A
To provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change.

Cyber Security *(2022/23)*
Executive Lead – Chief Executive Officer
The review sought to provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Follow Up High Recommendations *(2022-23)*
Executive Lead: Director of Corporate Governance

The review sought to determine if a sample of high priority recommendations had been implemented or recognised as still outstanding on the Audit Recommendation Tracking Tool.

Clinical Futures - Care Closer to Home (2022-23)
Executive Lead: Chief Operating Officer
This report is a consolidated summary of audit work completed over Clinical Futures – Care Closer to Home, but within three other audits encompassing the same area.

MONITORING AND IMPLEMENTATION OF AUDIT RECCOMENDATIONS

At the April 2022 meeting, the Audit, Risk and Assurance Committee received a Standard Operating Procedure (SOP) that outlined the purpose of the internal and external recommendation tracker process and provided a clear rationale as to how this benefits the organisation. The Committee adopted this SOP and since April 2022, a report on audit recommendations has been submitted to each meeting. Progress continues throughout the Health Board and key relationships with service leads is progressing to close, extend deadlines or complete the recommendations.

At the May 2023 the Committee is due to receive an internal audit review of the monitoring and tracking of high-level recommendations. At the time of writing, the internal audit report has not yet been formally received by the Committee however, the report's findings concluded a ***reasonable*** level of assurance.

Due to the sustained challenges across the health and care system, the Health Board has been required to balance risk across the breadth of the system which has, at times, resulted in delays in implementing audit recommendations. The Audit, Risk and Assurance Committee is committed to maintaining a focus on progress in implementing audit recommendations as a priority in 2023/24.

Head of Internal Audit's Opinion for 2022/23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2022/23 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and

exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit and Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales Structured Assessment Report for 2022, examined the arrangements the Health Board has in place to support good governance across key areas of the Health Board's business and the efficient, effective, and economic use of resources. The Report concluded with the following assessment:

"Overall, we found that while the Health Board is strengthening its governance arrangements, there is scope to enhance them further to address the significant challenges it needs to address in the short- and medium-term."

The report went on to say that:

"Board and committee arrangements are strengthening, but they will need to be enhanced further to enable the Health Board to focus on addressing the increasing financial and performance challenges it is facing. While recent changes to committee structures appear to be leading to balanced workloads, there is scope to refine the size and order of agendas and sharpen some papers to ensure they are more focussed."

"The Health Board is building greater leadership stability at an executive level through permanent appointments to key posts. It is also appropriately developing and embedding its systems of assurance, particularly its board assurance, risk management, and outcomes frameworks. The outcomes framework in particular is starting to help the Health Board to better monitor strategic objective delivery. However, there are opportunities to strengthen performance reporting relating to the impact of its improvement actions."

The Structured Assessment 2022, along with the Health Board's response is available on our website.

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the board and its Executive Directors are alert to their accountabilities in respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk. I am pleased to note that, as a result of our internal control arrangements, Aneurin Bevan University Health Board continues to be on 'routine' monitoring as part of NHS Wales Escalation and Intervention arrangements.

During 2022/23, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Further work will be undertaken in 2023/24 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2023/24 to embed risk management and the assurance framework at a corporate and operational level. Implementation of the Board's Annual Governance Priorities, set out within the IMTP 2023-26, will see a further strengthening of the Board's effectiveness and the system of internal control in 2023/24.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The Health Board will therefore need

to continually reflect and respond to the demands and challenges it faces in 2023/24 and beyond. I will ensure our Governance Framework considers and responds to this need.

Signed:

Nicola Prygodzicz
Chief Executive
Dated: XX 2023

MODERN SLAVERY ACT 2015 – TRANSPARENCY IN SUPPLY CHAINS –

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

The code of practice sets out a number of commitments and Procurement Services on behalf of the Health Board has commenced the preparation of an action plan so that it can monitor progress against these. As an example, The Health Board have included the requirement for all suppliers to meet the Act in our standard NHS Terms and Conditions of contract.

Also, following the Transparency in Supply Chains consultation (2019), the UK Government has committed to extend section 54 of the Modern Slavery Act 2015 to public bodies in England and Wales with a budget of £36m or more – This requires organisations to produce annual statements by 30th September of each financial year, that provide details of steps taken to prevent modern slavery in their operations and supply chain. A draft statement is being compiled by Procurement Service and Legal/Risk in readiness for the 30th of September deadline, reflecting the work to date, any further and emerging risks and appropriate mitigations.

The procurement function is a key area for ethical employment in supply chains. This is run by NHS Wales Shared Services Partnership (NWSSP) which is hosted by Velindre University NHS Trust (Velindre). More information can be found on the work done on the Health Board's behalf by NWSSP on the Shared Services Partnership website.

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Independent Members					
Ann Lloyd	Chair		Chair of the Board	7 out of 7	
			Chair, Remuneration and Terms of Service Committee	6 out of 6	
			Chair, Partnerships, Population Health and Planning Committee	3 out of 3	
Pippa Britton	Interim Vice Chair	From 18th October 2021	Member of the Board	5 out of 7	Mental Health
			Chair, Patient Quality, Safety and Outcomes Committee	5 out of 5	
			Chair, Mental Health Act Monitoring Committee	4 out of 4	
			Vice Chair, Remuneration and Terms of Service Committee	6 out of 6	
Katija Dew	Independent Member (Third Sector)		Member of the Board	7 out of 7	Older Persons
			Member, Audit, Risk and Assurance Committee	6 out of 7	
			Vice Chair, Partnerships, Population Health and Planning Committee	3 out of 3	
			Vice Chair, Mental Health Act Monitoring Committee	3 out of 4	
			Chair, Charitable Funds Committee	4 out of 4	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Shelley Bosson	Independent Member (Community)		Member of the Board	5 out of 7	Infection Prevention and Control
			Chair, Audit, Risk and Assurance Committee (until 1/10/22)	4 out of 4	
			Member, Audit, Risk and Assurance Committee (from 2/10/22)	3 out of 3	
			Member, Patient Quality, Safety and Outcomes Committee (until 1/11/22)	2 out of 3	
			Member, Finance and Performance Committee	3 out of 3	
			Member, Remuneration and Terms of Service Committee (until 1/11/22)	2 out of 3	
Louise Wright	Independent Member (Trade Union)		Member of the Board	6 out of 7	Children and Young People
			Vice Chair, Patient Quality, Safety and Outcomes Committee	4 out of 5	
			Chair, People and Culture Committee	3 out of 3	
			Member, Remuneration and Terms of Service Committee	6 out of 6	
			Vice Chair, Charitable Funds Committee	3 out of 4	
Richard G Clarke	Independent Member (Local Authority)		Member of the Board	5 out of 7	
			Vice Chair, Audit, Risk and Assurance Committee	6 out of 7	
			Chair, Finance and Performance Committee	3 out of 3	
			Member, Partnerships, Population Health and Planning Committee	3 out of 3	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Professor Helen Sweetland	Independent Member (University)		Member of the Board	5 out of 7	
			Member, Patient Quality, Safety and Outcomes Committee	4 out of 5	
			Member, People and Culture Committee	1 out of 3	
Paul Deneen	Independent Member (Community)		Member of the Board	7 out of 7	Equality
			Member, Audit, Risk and Assurance Committee	7 out of 7	
			Member, Patient Quality, Safety and Outcomes Committee	5 out of 5	
			Vice Chair, People and Culture Committee	3 out of 3	
			Member, Mental Health Act Monitoring Committee	4 out of 4	
Iwan Jones	Independent Member (Finance)	From 04/04/2022	Member of the Board	6 out of 7	
			Chair, Audit, Risk and Assurance Committee (from 1/10/22)	3 out of 3	
			Vice Chair, Finance and Performance Committee	3 out of 3	
			Member, Remuneration and Terms of Service Committee (from 1/11/22)	3 out of 3	
			Member, Charitable Funds Committee (from 1/11/22)	2 out of 2	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Dafydd Vaughan	Independent Member (Digital)	From 09/05/2022	Member of the Board	5 out of 7	
			Member, People and Culture Committee (from 1/11/22)	1 out of 1	
			Member, Finance and Performance Committee (from 1/11/22)	1 out of 1	
			Member, Partnerships, Population Health and Planning Committee (from 1/11/22)	0 out of 1	
Associate Members					
Keith Sutcliffe	Chair, Stakeholder Reference Group	Until 30/11/2022	Associate Member of the Board	4 out of 5	Armed Forces & Veterans
			Member, Charitable Funds Committee (until 1/11/22)	0 out of 2	

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Executive Directors					
Nicola Prygodzicz	Chief Executive	From 5/9/2022	Member of the Board	4 out of 4	
			Member, Charitable Funds Committee (from 5/9/22)	3 out of 3	
			Attendee as requested at all Board Committees		
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT / Interim Deputy Chief Executive	Until 4/9/2022	Member of the Board	3 out of 3	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Glyn Jones	Interim Chief Executive	Until 5/9/2022	Member of the Board	3 out of 3	
			Member, Charitable Funds Committee (until 5/9/22)	0 out of 1	
			Attendee as requested at all Board Committees		
Rob Holcombe	Interim Director of Finance, Procurement and Value Based Healthcare Director of Finance and Procurement	Until 13/11/22 From 14/11/22	Member of the Board	7 out of 7	
			Member, Charitable Funds Committee	4 out of 4	
			Required Attendee: Audit, Finance and Risk Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Dr James Calvert	Medical Director Medical Director/Deputy Chief Executive	Until 23/09/2023 From 24/09/2023	Member of the Board	6 out of 7	Caldicott
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Sarah Simmonds	Director of Workforce and OD		Member of the Board	7 out of 7	Raising Concerns Welsh Language
			Required attendee: People and Culture Committee		
			Attendee as requested at all Board Committees		
Chris Dawson-Morris	Interim Director of Planning and Performance	From 05/09/2022 – 3/04/2023	Member of the Board	4 out of 4	Emergency Planning
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Hannah Evans	Director of Strategy, Planning and Partnerships	From 1/4/2023	Member of the Board		Emergency Planning
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Rhiannon Jones	Director of Nursing	Until 05/07/2022	Member of the Board	1 out of 2	Children and Young People Infection Prevention and Control Putting Things Right
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Linda Alexander	Interim Director of Nursing	25/06/2022 to 15/08/2022	Member of the Board	1 out of 1	Children and Young People Infection Prevention and Control Putting Things Right
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Jennifer Winslade	Director of Nursing	From 08/08/2022	Member of the Board	4 out of 4	
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		
Peter Carr	Director of Therapies and Health Sciences		Member of the Board	6 out of 7	Fire Safety Violence and Aggression
			Required attendee: Patient Quality, Safety and Outcomes Committee		
			Attendee as requested at all Board Committees		

Name	Position and Area of Expertise	Dates (if not full year)	Board Committee Membership	Attendance	Champion Role
Dr Sarah Aitken*	Director of Public Health and Strategic Partnerships	Until 05/01/2023	Member of the Board	4 out 5	
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Tracy Daszkiewicz*	Director of Public Health	From 01/04/2023	Member of the Board		
			Required Attendee: Partnerships, Population Health and Planning Committee		
			Attendee as requested at all Board Committees		
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services		Member of the Board	5 out of 7	
			Required attendee: Mental Health Act Monitoring Committee		
			Attendee as requested at all Board Committees		
Directors in Attendance					
Leanne Watkins	Director of Operations	From 17th March 2022	Attendee at the Board	6 out of 7	
			Attendee as requested at all Board Committees		
Director of Corporate Governance					
Rani Dash (nee Mallison)	Director of Corporate Governance		Attendee at the Board	7 out of 7	
			Attendee as requested at all Board Committees		

**Director of Public Health - During the vacancy period 05/01/23 to 01/04/2023, Stuart Bourne and Eryl Powell, Deputy Directors of Public Health, provided advice to the Board and attended meetings in their deputy roles.*

Quoracy of Meetings | Quorate | Non-Quorate |

Board/Committee	Date						
Board	25 May 2022	14 June 2022	27 July 2022	28 September 2022	30 November 2022	25 January 2023	29 March 2023
Patient Quality, Safety and Outcomes Committee	5 April 2022	7 June 2022	16 August 2022	18 October 2022 - CANCELLED	6 December 2022	7 February 2023	
Audit, Risk and Assurance Committee	7 April 2022	17 May 2022	13 June 2022	2 August 2022	6 October 2022	1 December 2022	2 February 2023
Charitable Funds Committee	2 August 2022*	27 October 2022	19 January 2023	2 March 2023			
Partnerships, Population Health and Planning Committee	25 April 2022	7 July 2022	16 November 2022				
Mental Health Act Monitoring Committee	13 June 2022	6 September 2022	8 December 2022	9 March 2023			
Finance and Performance Committee	6 July 2022	5 October 2022	11 January 2023				
People and Culture Committee	14 April 2022*	13 September 2022	10 January 2023				
Remuneration and Terms of Service Committee	6 June 2022	5 July 2022	7 September 2022	29 November 2022	14 February 2023	29 March 2023	

*Meeting attended by additional IM to ensure quoracy

Attachment Two

Ministerial Directions

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Implemented	**Complete**
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2022	07/04/2022	Implemented	**Complete**
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2022	09/06/2022	Implemented	**Complete**
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 3) (Wales) Regulations 2022	29/06/2022	Regulation has been implemented. Monkeypox has been added to the 'non chargeable' category of diseases.	**complete**
The Pharmaceutical Services (Advanced Services) (Appliances) (Wales) (Amendment) Directions 2022	29/07/2022	The amendments are published in the drug tariff and are publicly available. In this instance the directions are not tasking the Health Board to action anything as it's an update of existing arrangements, so there's nothing to disseminate. Additionally, although we maintain provision for pharmacies or appliance contractors to commission stoma appliance customisation and Appliance Use Reviews (covered in our PNA) the Health Board does not have any pharmacies providing the service or any appliance contractors on our list.	**complete**
The Primary Medical Services (Influenza and Pneumococcal Immunisation Scheme) (Directed Enhanced Service) (Wales) (No. 2)	08/08/2022	Implemented	**Complete**
The Primary Care (Contracted Services: Outpatient Waiting List Scheme) Directions 2022	12/08/2022	Lead with Planned Care Board. Practices asked if they wish to participate - no further action taken at this time	**Complete**
Primary Care Contracted Services: Immunisations (PCCS:I) Amending Directions August 2022	25/08/2022	Implemented	**Complete**

Ministerial Directive	Date Issued	Action to demonstrate implementation/response	Rating
The Abortion Act 1967 – Revocation of the Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2022	26/08/2022	The HB already allow patients to administer medications to induce a legal abortion in their own home. The medications will have been prescribed by a hospital based doctor after completing the appropriate `blue form`	**complete**
The National Health Service (Charges to Overseas Visitors) (Amendment) (No. 4) (Wales) Regulations 2022	22/11/2022	Regulation has been implemented. Guernsey and Malta have been added to the list of countries where the Health Board has reciprocal arrangements.	**complete**
The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2022	30/11/2022	This regulation has been implemented as required - by NWSSP.	**complete**
The Wales Infected Blood Support Scheme (Amendment) (No. 2) Directions 2022	08/12/2022	Ministerial Direction implemented by NWSSP on behalf of Wales Infected Blood Support Scheme (WIBSS) - WIBSS has written to all current beneficiaries of WIBSS to bring this to their attention and also included a reference in the December 2022 Newsletter. As at 31 March 2023 18 applications had been processed in respect of 31 children; amounting to a commitment of £69,600	**Complete**
The Local Health Boards (Directed Functions) (Wales) Directions 2022	15/12/2022	Implemented	**Complete**
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	Implemented	**Complete**
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2023	13/01/2023	Implemented	**Complete**
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2023	21/02/2023	Implemented	**Complete**
Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023	24/03/2023	Implemented	**Complete**

Welsh Health Circulars

Date Issued	Name & No. of WHC	Progress	Rating
15/02/2022	**WHC/2022/007** Recording of Dementia Read Codes	Issued and Implemented	**complete**
01/03/2022	**WHC/2022/014** Healthcare associated infections and antimicrobial resistance improvement goals	The HCAI Welsh Government expectations against the nationally reportable infections are reported at every PQSO Committee, with performance oversight via RNTG.	**complete**
24/03/2022	**WHC/2022/011** COVID-19 patient testing framework	Issued and Implemented	**complete**
29/03/2022	**WHC/2022/010** Reimbursable vaccines and eligible cohorts for the 2022 to 2023 NHS seasonal influenza (flu) vaccination programme	Issued and Implemented	**complete**
24/03/2022	**WHC/2022/005** Welsh Value in Health Centre: data requirements	Issued and Implemented	**complete**
04/04/2022	**WHC/2022/09** Prioritisation of COVID-19 patient episodes by NHS Wales clinical coding departments	Continue to prioritise the coding of COVID-19 patients as per the WG directive.	**complete**
21/04/2022	**WHC/2022/006** Direct paramedic referral to same day emergency care: All Wales policy	The Flow Centre currently manages SDEC referrals. Surgical for GUH and Medical for YYF. Currently WAST are included in this for YYF but not for GUH. WAST referrals are triaged on arrival at the GUH and will be considered for SDEC under the ED-to-SDEC Pathway.	**In progress**
27/04/2022	**WHC/2022/13** Health boards, special health authorities and trusts financial monitoring guidance 2022 to 2023	Issued and Implemented	**complete**
01/06/2022	**WHC/2022/015** Changes to the vaccine for the HPV immunisation programme	Information on changes to schedules is cascaded centrally from PHW and WG	**complete**
01/06/2022	**WHC/2022/16** The national influenza immunisation programme 2022 to 2023	Dual offer made alongside covid in mass vaccination centres.	**complete**

Date Issued	Name & No. of WHC	Progress	Rating
14/06/2022	**WHC/2022/002** NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023	The new clinical audit plan (soon to be published) has a full list all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. Participation is mandatory and the list has been shared with all Divisions. The list is published with a nine month rolling programme. The clinical audit plan will be updated continually to capture all actions and improvements. The AD for Quality and Patient Safety has presented the Clinical Audit Strategy to all Divisional meetings. This included changing recording updates to the web based audit tracking system (AMaT). As each National Clinical Audit (NCA) is published, the results are uploaded to AMaT and assigned to a Clinical Lead. The Clinical Lead will attend the Clinical Standards and Effectiveness Group to present the results. A standardised template for the results is being produced to enable our annual audit report to present the findings and actions from each audit. AMaT is being used to record audit results, track progress and document successes and challenges. It is being used to develop an action plan within SMART objectives. AMaT training has been carried out throughout ABUHB over the past six months.	**Complete**
16/06/2022	**WHC/2022/12** Donation and transplantation plan 2022 to 2026	Plan is accounted for as part of IMTP planning processes.	**complete**
16/06/2022	**WHC/2022/17** Wales rare diseases action plan 2022 to 2026	The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to ensure ABUHB adheres to the four key priorities outlined in the plan.	**complete**
21/06/2022	**WHC/2022/019** NHS Wales non specialised paediatric orthopaedic services	Stakeholder response Proforma submitted in March 2022 outlining service provision of level 1 and level 2 services. Both services are able to be maintained in ABUHB with the current level of paediatric anaesthetic, radiology and general medical cover. Inter-organisational discussions between Consultants ongoing to agree on levels of transfer according to available capacity.	**complete**
30/06/2022	**WHC/2022/18** Suspected cancer pathway: guidelines	Fully compliant	**complete**
22/07/2022	**WHC/2022/20** Never events: policy and incident list July 2022	SI team shared the WHC with the divisions and also published on the intranet	**complete**

Date Issued	Name & No. of WHC	Progress	Rating
28/07/2022	**WHC/2022/21** National optimal pathways for cancer	Issued and Implemented	**complete**
29/07/2022	**WHC/2022/008** New records management code of practice for health and care 2022	Issued and Implemented	**complete**
22/08/2022	**WHC/2022/022** The role of the Community Dental Service	Discussed at Primary Care Senior Leadership Team and satisfied that progress is being made in line with the WHC	**In progress**
09/09/2022	**WHC/2022/023** Changes to the vaccine for the HPV immunisation programme	Information on changes to schedules is cascaded centrally from PHW and WG	**complete**
11/10/2022	**WHC/2022/026** Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning	Forwarded to relevant parts of the organisation.	**complete**
24/10/2022	**WHC/2022/027** Urgent polio catch-up programme for children under 5 years old	Implemented - gone beyond requirements: MVCs offered scheduled immunisations to children in 17 GP practices that opted out of enhanced service inc. domiciliary vaccination visits.	**complete**
31/10/2022	**WHC/2022/003** Guidance for the provision of continence containment products for Adults in Wales 2022	Issued and Implemented	**complete**
31/10/2022	**WHC/2022/004** Guidance for the care of children and young people with continence problems	Issued and Implemented	**complete**
22/11/2022	**WHC/2022/029** Follow-up advice on the polio catch-up programme for children under 5 years old	As above: since April we have sought self-reported uptake from GPs delivering enhanced service. MVCs currently evaluating uptake within 17 opt out practices.	**complete**
08/12/2022	**WHC/2022/031** Reimbursable vaccines and eligible cohorts for the 2023 to 2024 NHS seasonal influenza (flu) vaccination programme	Issued and Implemented: position endorsed by Gwent LMC.	**complete**
16/12/2022	**WHC/2022/025** All Wales guidance for prescribing intervals	Message sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	**complete**
22/12/2022	**WHC/2022/035**	Issued and Implemented: MVCs offered walk-in service from end of Dec 2022 and by the end of the season administered over 7,000 additional vaccines.	**complete**

Date Issued	Name & No. of WHC	Progress	Rating
	Influenza (flu) vaccination programme deployment 'mop up' 2022 to 2023		
16/01/2023	**WHC/2023/001** Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024	Multi-agency steering group established, baseline position in place, and reviewing priorities to inform joint recovery plan. JRP submission date extended by WG to mid-July.	**In progress**
31/01/2023	**WHC/2023/002** Faecal immunochemical testing (FIT) in symptomatic colorectal cancer referral	This was actioned within the Health Board before the WHC circulation and discussed at cancer Board on the 18th January	**complete**
15/02/2023	**WHC/2022/034** Health board allocations for 2023 to 2024	Complete and has informed the IMTP and budget setting / delegation approvals	**complete**
24/03/2023	**WHC/2022/032** Further extending the use of Blueteq in secondary care	Discussed at Chief Pharmacists meeting of 3/4/23 with representatives of AWTTC. Plan to discuss at MMPB 13/4/23. "Following the WG mandate to implement Blueteq within all HBs/Trusts a number of questions have been raised. Implementation will be through a staged approach and the aim is to start off with Rheumatology and then Haematology. BCUHB is to undertake a pilot in rheumatology and HBs will be able to learn from this and share how they have approached it e.g. training etc. Templates have been produced and the plan is to have a generic template that can be used across Wales so individual HBs/Trust don't need to develop their own. BCUHB is in the process of working through the IG and DPIA issues and hope to start the pilot in May. For Haematology it is planned to look at all drugs that have commercial access agreements linked to them and develop templates. It is intended to use some of the NHS England templates and adapt for Wales but as we progress ahead of England we will need to develop our own. CPG requested that as more detail is available this is shared with it so CPG can assess the increased workload for staff and start putting the relevant processes in place."	**complete**
08/03/2023	**WHC/2023/004** COVID-19 spring booster 2023	Implemented as required and on target for delivery and uptake as planned	**In progress**
31/03/2023	**WHC/2023/007** Patient testing framework, updated guidance	Implemented and interpreted locally. On-going discussions in place with PHW regarding support from AWARe in relation to care home testing.	**complete**
31/03/2023	**WHC/2023/006** Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020	Quality Strategy and Patient Experience and Involvement Strategy approved and implementation underway. Training session held for Board members	**In progress**

Attachment Three

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2022/23

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2022
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress against the Health Board Integrated Medium Term Plan 2022-2025, which adopts a life course approach, is presented to the Board on a quarterly basis.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2022 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance • Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the statutory requirements into day to day operating practice, and, together with the adoption of a Schedule of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2022 Board and Committee Agenda and Meeting Papers

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control.	Comply	Accountability Report
2.12	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes.	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	Board and Committee Agenda and Papers Role of the Director of Corporate Governance
3.1 3.11 3.12 3.13	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation	Comply	Health Board Establishment Orders Standing Orders Board Member Induction checklist

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments. It is acknowledged that there have been a number of changes to Board membership, in terms of both Independent Members and Executive Directors during 2022/23. The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professional qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment highlights that *"Independent Members continue to engage and participate fully in meetings and provide reasonably effective scrutiny and questioning of the information presented. However, there is scope for Independent Members to provide a stronger focus on what difference is being made and to strengthen their challenge on the risks that might affect the successful delivery of Health Board plans."* *"There have been new appointments to the Board, and it is becoming more cohesive."* There is a national programme of induction, in which all members are asked to participate. This is organised by Academi Wales and Welsh Government. Tailored programmes of induction have commenced for new Independent Members, however there is further work to do on building a comprehensive programme for future use. There is also a programme of Board Development Sessions and Board Briefings and other training made available to the Board.	Comply	Audit Wales Structured Assessment 2022 Independent Member Induction Pack

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
3.15	The Board should agree and document in its board operating framework a *de minimis* threshold and mechanisms for board advice on the operation and delivery of policy proposals.	A forward work programme of Board Business is in place and approved on an annual basis. The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.		Board Forward Work Programme Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date 4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure succession planning is timely and managed in conjunction with the public appointments unit. Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions.		Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members. Agenda and papers for Board meetings are published one week prior to the meeting. Report templates have been revised to ensure to support the provision of appropriate and relevant information. The Corporate Governance function supports Board and Committee Business. A consultation process has been undertaken and the final outcome awaited in relation to this function to increase capacity within the team and ensure appropriate skills and expertise are in place. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. From 2023/24, Committees will undertake a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.		
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles.	Comply	Terms of Reference for Board Committees Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.		
4.6	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate.	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed prior to publication to ensure the quality or reports and maximum transparency and openness in the way in which the organisation conducts its business.	Comply	Board Secretary role profile

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence

4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include:
	
	• developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention
	• ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:
	  • challenging and ensuring the quality of board papers and board information
	  • ensuring board papers are received by board members according to a timetable agreed by the board
	  • providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements
	  • ensuring the board follows due process
	  • providing assurance to the board that the department:
	  • complies with government policy, as set out in the code
	  • adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts)
	  • acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings
		The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description
				
				Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up • arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties).	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former reported to the Remuneration and Terms of Service Committee.	Comply	Appraisal documentation and process
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	board, not a committee. The board should be supported by: • an audit and risk assurance committee, chaired by a suitably experienced non-executive board member • an internal audit service operating to Public Sector Internal Audit Standards1 • sponsor teams of the department's key ALBs	NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.		Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular, advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.	Comply	Accountability Report
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Strategy and Board Assurance Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management. A Corporate Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and		Board and Committee Agendas and papers Risk Management Strategy Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Corporate Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team. 5 Independent Members comprise the Audit, Risk and Assurance Committee. The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.			
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently.	The Health Board has an agreed Risk Management Strategy. Development work continues to review and refine the Risk Management Strategy, with a Board Development session held in March 2022 focused on strategic risk management and assurance arrangements, including risk appetite and tolerance which will be a key element of the updated Risk Management Strategy. The Risk Management Strategy articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Corporate Services, Risk and Assurance.	Comply	Risk Management Strategy Corporate Risk Register

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.			

Remuneration and Staff Report 2022/23

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2022/23, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Pippa Britton, Vice Chair of the Board;
- Shelley Bosson, Chair of Audit, Risk and Assurance Committee (Until 31/10/2022)
- Iwan Jones, Chair of Audit, Risk and Assurance Committee (From 1/11/2022)
- Louise Wright, Independent Member (Trade Union).

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2022/23 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2022/23 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2022/23, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions are in line with those set by Welsh Government as part of the NHS Reform Programme of 2009. During 2022/23 there were three (3) interim Directors in post; an Interim Chief Executive, an Interim Director of Primary, Community Care and Mental Health and Interim Director of Finance, Procurement and VBHC. Further detail on interim appointments can be found in the Annual Governance Statement.

The Remuneration and Terms of Service Committee considers issues of equality and diversity when evaluating and setting remuneration for Directors', particularly in relation to gender and ethnicity in pay levels, in line with Welsh Government's Framework.

Salary and Pension Disclosure Table: Salaries and Allowances

Remuneration Report

Salary and Pension entitlements of Senior Managers Remuneration

		2022-23					2021-22				
Name	**Title**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**	**Full Year Equivalent Salary (bands of £5,000)**	**Salary (bands of £5,000)**	**Benefits in kind (to nearest £100)**	**Pension Benefits**	**Total (bands of £5,000)**
		£000	**£000**	**£00**	**£000**	**£000**	**£000**	**£000**	**£00**	**£000**	**£000**
Executive Directors											
Judith Paget	Chief Executive (Until 31.10.21)						215 - 220	125 - 130	0	54	175 - 180
Glyn Jones	Deputy Chief Executive (From 05.09.22 Until 23.09.22)	205 - 210	100 - 105	0	32	135 - 140					
	Interim Chief Executive (From 01.11.21 Until 04.09.22)						200 - 205	175 - 180	0	81	255 - 260
	Director of Finance & Performance / Deputy Chief Executive (Until 31.10.21)						155 - 160				
Nicola Prygodzicz	Chief Executive (From 05.09.22)	215 - 220	165 - 170	12	282	450 - 455					
	Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (From 01.11.21 Until 04.09.22)	125 - 130					125 - 130	120 - 125	6	10	130 - 135
	Director of Planning, Digital & IT (Until 31.10.21)						115 - 120				
Dr James Calvert	Medical Director / Deputy Chief Executive (From 24/09/22)	190 - 195	195 - 200	0	66	260 - 265					
	Medical Director (Until 23.09.22)	185 - 190						185 - 190	0	290	475 - 480
Robert Holcombe	Director of Finance and Procurement (From 14.11.22)	150 - 155	155 - 160	0	200	355 - 360					
	Interim Director of Finance, Procurement and Value Based Healthcare (From 01.11.21 Until 13.11.22)	150 - 155					145 - 150	60 - 65	0	72	130 - 135
Chris Dawson-Morris	Interim Director of Planning and Performance (From 05.09.22)	125 - 130	75 - 80	0	15	90 - 95					
Jennifer Winslade	Director of Nursing (From 08.08.22)	135 - 140	90 - 95	0	59	150 - 155					
Linda Alexander	Director of Nursing (From 25.06.22 Until 14.08.22)		15 - 20	0	10	25 - 30					
Rhiannon Jones	Director of Nursing (Until 05.07.22)		35 - 40	0	7	40 - 45		135 - 140	0	60	195 - 200
Geraint Evans	Director of Workforce and Organisational Development (Until 31.08.21)						135 - 140	55 - 60	0	0	55 - 60
Sarah Simmonds	Director of Workforce and Organisational Development (From 22.07.21)		140 - 145	15	72	215 - 220	135 - 140	90 - 95	4	104	195 - 200
Dr Sarah Aitken	Director of Public Health and Strategic Partnerships (From 18.01.21 Until 05.01.23)	130 - 135	95 - 100	0	0	95 - 100					
	Interim Director of Primary, Community and Mental Health Services (From 06.12.21 Until 28.02.22)						125 - 130	125 - 130	0	0	125 - 130

Peter Carr	Director of Therapies and Health Sciences		110 - 115	25	16	130 - 135		110 - 115	126	45	165 - 170
Nick Wood	Director of Primary, Community and Mental Health (Until 05.12.21)						145 - 150	100 - 105	2	29	130 - 135
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (From 28.02.22)		145 - 150	0	212	360 - 365	135 - 140	10 - 15	0	4	15 - 20
Director of Operations											
Claire Birchall	Director of Operations (Until 02.05.21)						110 - 115	10 - 15	0	0	10 - 15
Leanne Watkins	Director of Operations (From 17.03.22)		120 - 125	17	32	155 - 160					
	Interim Director of Operations (From 12.04.21 Until 16.03.22)						110 - 115	105 - 110	39	86	195 - 200
Board Secretary / Director of Corporate Governance											
Richard Howells	Interim Board Secretary (Until 30.11.21)						90 - 95	60 - 65	0	90	150 - 155
Rani Dash	Director of Corporate Governance (From 14.03.22)		110 - 115	56	41	155 - 160	100 - 105	35 - 40	18	9	50 - 55
	Board Secretary (From 28.11.21 Until 13.03.22)										
Special Advisor to the Board											
Philip Robson	Special Advisor to the Board		15 - 20	0	0	15 - 20		35 - 40	0	0	35 - 40
Chris Koehli	Special Advisor to the Board (Until 17.07.21)						35 - 40	5 - 10	0	0	5 - 10
Non-Executive Directors											
Ann Lloyd CBE	Chair		65 - 70	0	0	65 - 70		65 - 70	0	0	65 - 70
Emrys Elias	Vice Chair (Until 30.09.21)						55 - 60	25 - 30	0	0	25 - 30
Pippa Britton	Interim Vice Chair (From 18.10.21)		55 - 60	0	0	55 - 60	55 - 60	30 - 35	0	0	30 - 35
	Independent Member (Community) (Until 17.10.21)						15 - 20				
Katija Dew	Independent Member (Third/Voluntary Sector)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Prof. Helen Sweetland	Independent Member (University)		0	0	0	0		0	0	0	0
Richard Clark	Independent Member (Local Authority)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Paul Deneen	Independent Member (Community)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Shelley Bosson	Independent Member (Community)		15 - 20	0	0	15 - 20		15 - 20	0	0	15 - 20
Dafydd Vaughan	Independent Member (Digital) (From 09.05.22)	15 - 20	10 - 15	0	0	10 - 15					
Iwan Jones	Independent Member (Finance) (From 04.04.22)	15 - 20	15 - 20	0	0	15 - 20					
Louise Wright	Independent Member (Trade Union)		0	0	0	0		0	0	0	0
Keith Sutcliffe	Associate Independent Member (Chair of Stakeholder Group) (Until 30.11.22)		0	0	0	0		0	0	0	0

	2022-23		2021-22	
	Pay	Ratio	Pay	Ratio
Band of Highest paid Director's Total Remuneration £000	215 - 220		200 - 205	
25th percentile pay £	26,282	8.3	24,883	8.1
Median pay £	33,428	6.5	32,008	6.3
75th percentile pay £	43,078	5.0	41,837	4.8

Salary has been reported as gross pay, which is before the deduction of any salary sacrifice schemes. During 2022-23 Nicola Prygodzicz had £7k salary sacrificed in respect of the lease car scheme, Jennifer Winslade had less than £1k sacrificed in respect of pensions, Sarah Simmonds had £8k sacrificed in respect of the lease car scheme and less than £1k sacrificed in respect of pensions, Leanne Watkins had £11k sacrificed in respect of the lease car scheme and less than £1k in respect of the cycle to work scheme and Rani Dash had £7k sacrificed as part of the lease car scheme.

The post of Special Advisor to the Board has been disclosed as it has been deemed to have an influence over board decisions.

The amount of pension benefits for the year which contributes to the single total figure is calculated using a similar method to that used to derive pension values for tax purposes and is based on information received from NHS BSA Pensions Agency.

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

The Health Board continues to pay two former chief executives who are currently on secondment to Welsh Government. Andrew Goodall has been seconded since 8th June 2014 and Judith Paget has been seconded since 1st November 2021.

The details of the remuneration received by these individuals is disclosed in the accounts of the Welsh Government, and the Health Board is reimbursed for the employment costs incurred. The salary banding included for Andrew Goodall is £215,000 to £220,000 (£215,000 to £220,000 2021-22) and for Judith Paget is £215,000 to £220,000 (£85,000 to £90,000 2021-22).

Remuneration Report continued

Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Glyn Jones	Deputy Chief Executive (From 05.09.22 Until 23.09.22) Interim Chief Executive (From 01.11.21 Until 04.09.22) Director of Finance & Performance / Deputy Chief Executive (Until 31.10.21)	0.0 - 2.5	0.0	35 - 40	0	569	474	24	0
Nicola Prygodzicz	Chief Executive (From 05.09.22) Director of Planning, Performance, Digital & IT / Interim Deputy Chief Executive (From 01.11.21 Until 04.09.22) Director of Planning, Digital & IT (Until 31.10.21)	12.5 - 15.0	30.0 - 32.5	60 - 65	135 - 140	1175	874	253	0
Dr James Calvert	Medical Director / Deputy Chief Executive (From 24/09/22) Medical Director (Until 23.09.22)	2.5 - 5.0	0.0 - 2.5	75 - 80	170 - 175	1589	1440	77	0
Robert Holcombe	Director of Finance and Procurement (From 14.11.22) Interim Director of Finance, Procurement and Value Based Healthcare (From 01.11.21 Until 13.11.22)	10.0 - 12.5	20.0 - 22.5	50 - 55	105 - 110	965	735	186	0
Chris Dawson-Morris	Interim Director of Planning and Performance (From 05.09.22)	0.0 - 2.5	0.0	5 - 10	0	78	55	2	0
Jennifer Winslade	Director of Nursing (From 08.08.22)	2.5 - 5.0	2.5 - 5.0	55 - 60	110 - 115	1088	948	60	0
Linda Alexander	Director of Nursing (From 25.06.22 Until 14.08.22)	0.0 - 2.5	0.0 - 2.5	35 - 40	105 - 110	864	746	12	0
Rhiannon Jones	Director of Nursing (Until 05.07.22)	0.0 - 2.5	0.0 - 2.5	65 - 70	190 - 195	0	1336	0	0
Sarah Simmonds	Director of Workforce and Organisational Development (From 22.07.21)	2.5 - 5.0	5.0 - 7.5	30 - 35	50 - 55	479	396	52	0
Peter Carr	Director of Therapies and Health Sciences	0.0 - 2.5	(2.5) - 0.0	40 - 45	85 - 90	753	700	17	0
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services (From 28.02.22)	10.0 - 12.5	20.0 - 22.5	50 - 55	100 - 105	909	683	184	0
Leanne Watkins	Director of Operations (From 17.03.22) Interim Director of Operations (From 12.04.21 Until 16.03.22)	0.0 - 2.5	0.0 - 2.5	40 - 45	80 - 85	671	612	26	0
Rani Dash	Director of Corporate Governance (From 14.03.22) Board Secretary (From 28.11.21 Until 13.03.22)	2.5 - 5.0	0.0 - 2.5	20 - 25	35 - 40	299	256	21	0

Sarah Aitken has not contributed to the NHS Pension Scheme during 2022-23

Rhiannon Jones has retired therefore no CETV is available.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government has taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

- clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provision of £141,451 (as notified by Welsh Government) within these accounts.

Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

In 2022-23, 15 (2021-22, 7) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £14k to £416k (2021-22, £19k to £338k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

		2022-23	2022-23	2022-23		2021-22	2021-22	2021-22
		£000	£000	£000		£000	£000	£000
Total pay and benefits		**Chief Executive**	**Employee**	**Ratio**		Chief Executive	Employee	Ratio
	25th percentile pay ratio	**215 - 220**	**26**	**8.3**		200 - 205	25	8.1
	Median pay	**215 - 220**	**33**	**6.5**		200 - 205	32	6.3
	75th percentile pay ratio	**215 - 220**	**43**	**5.0**		200 - 205	42	4.8
Salary component of total pay and benefits								
	25th percentile pay ratio	**215 - 220**	**26**			200 - 205	25	
	Median pay	**215 - 220**	**33**			200 - 205	32	
	75th percentile pay ratio	**215 - 220**	**43**			200 - 205	42	
Total pay and benefits		**Highest Paid Director**	**Employee**	**Ratio**		Highest Paid Director	Employee	Ratio
	25th percentile pay ratio	**215 - 220**	**26**	**8.3**		200 - 205	25	8.1
	Median pay	**215 - 220**	**33**	**6.5**		200 - 205	32	6.3
	75th percentile pay ratio	**215 - 220**	**43**	**5.0**		200 - 205	42	4.8
Salary component of total pay and benefits								
	25th percentile pay ratio	**215 - 220**	**26**			200 - 205	25	
	Median pay	**215 - 220**	**33**			200 - 205	32	
	75th percentile pay ratio	**215 - 220**	**43**			200 - 205	42	

Financial year summary

There has been an increase in the pay ratio which attributable to the increase in the chief executive / highest paid director salary being greater than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes						**2021-22**		2020-21
						to		to
						2022-23		2021-22
% Change from previous financial year in respect of Chief Executive						**%**		**%**
	Salary and allowances					**7**		(2)
	Performance pay and bonuses					**0**		0
% Change from previous financial year in respect of highest paid director								
	Salary and allowances					**7**		(2)
	Performance pay and bonuses					**0**		0
Average % Change from previous financial year in respect of employees takes as a whole								
	Salary and allowances					**5**		**5**
	Performance pay and bonuses					**0**		**0**

STAFF REPORT

Staff Numbers

9.2 Average number of employees

	Permanent Staff Number	Staff on Inward Secondment Number	Agency Staff Number	Specialist Trainee (SLE) Number	Collaborative Bank Staff Number	Other Number	Total Number	2021-22 Number
Administrative, clerical and board	2,677	20	30	0	0	0	**2,727**	2,582
Medical and dental	758	6	82	393	0	20	**1,259**	1,234
Nursing, midwifery registered	3,736	7	248	0	0	0	**3,991**	4,051
Professional, Scientific, and tech	460	0	2	0	0	0	**462**	436
Additional Clinical Services	2,668	0	209	0	0	0	**2,877**	2,792
Allied Health Professions	802	0	27	0	0	0	**829**	804
Healthcare Scientists	230	4	11	0	0	0	**245**	243
Estates and Ancilliary	975	0	171	0	0	0	**1,146**	1,145
Students	10	0	0	0	0	0	**10**	4
Total	**12,316**	**37**	**780**	**393**	**0**	**20**	**13,546**	13,291

Staff Composition

The table above provides the breakdown of staff numbers per discipline and professional group within the Health Board.

The gender breakdown for all staff groups as at 31 March 2023 is provided below:

	2022-2023			2021-2022			2020-2021		
	Directors	**WTE**	**%**	**Directors**	**WTE**	**%**	**Directors**	**WTE**	**%**
Female	5	10,127	80.06%	4.78	9722.1	79.27%	5.78	9762.8	79.29%
Male	6	2521.5	19.94%	6	2543.1	20.73%	5	2549.2	20.71%
Total	**11**	**12,648.50**		**10.78**	**12,265.20**		**10.78**	**12,312**	

The total number of staff per discipline will differ from the staff numbers shown in the gender breakdown table as the gender figures are based on a point in time as of 31 March 2023 whereas the staff per discipline numbers represent the average over a 52 week period of staff in post.

Sickness Absence Data

The Health Board has monitored absence in various categories as set out in this section.

The Health Board's sickness absence rate for 2022/2023 is 6.74%, an increase for sickness related absence from 6.30% in 2021/2022 which was a slight reduction in the previous year of 6.47% in 2020/2021. Sickness absence remained above 6% for every month, with the exception of March 2023, which reduced to 5.94%. December 2022 recorded the highest sickness absence at 7.83%. 0.82% of the sickness was due to Covid 19.

Over the past 5 years, the average working days lost per individual has increased slightly year on year. In 2021/2022 the average sickness days lost was 17.2 per individual employee, which increased to 18 days in 2022/23.

The table below provides the sickness absence trend data for the Health Board over the last eight years.

Sickness Absence	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Days Lost (Short Term <28 days)	61261	53097	60406	54759	68229	60411	79761	98573
Days Lost (Long Term >28 days)	144562	147711	153345	162684	194289	188778	203781	205131
Total Days Lost	205823	200808	213751	217443	262518	249189	283542	303704
Total Staff Years	902	880	937	954	1156	1093	1249	1350
Average Working Days Lost	14.7	14.2	15.2	15.2	15.2	16	17.2	18
Total staff employed in period (headcount)	14020	14155	10412	14334	14835	15528	15863	16245
Total staff employed with no absence (headcount)	4919	5803	4848	5016	5402	6055	5710	5035
Percentage staff with no sick	40%	41%	37%	35%	36%	39%	36%	31%

Medical Exclusion

Medical exclusion is a term used to record those staff who have had to self-isolate for a number of reasons, for example a household member having Covid-19 symptoms, being contacted through Track, Trace and Protect, or being classified as extremely clinically vulnerable and therefore having to shield for two separate periods of time as a result of Welsh Government advice.

The prevalent variant of Covid-19 and the high rates of immunity in the population has meant that Covid-19 is currently a milder infection. This has resulted in Welsh Government testing guidance being amended to reflect this change. As of 01 April 2023, routine testing for all staff is no longer a requirement, which will result in a further reduction of staff being medically excluded from the workplace.

The table below highlights how the pandemic impacted on attendance overall, with a further 10,952 days lost due to staff having to be medically excluded which is much lower than 2021/22:

Sickness Absence	2019/20	2020/21	2021/22	2022/23
Days Lost (Short Term <28 days)	6779	36331	18389	9836
Days Lost (Long Term >28 days)	2439	57707	7208	1116
Total Days Lost	9218	94038	25597	10952
Total Staff Years	40	412	90	41
Average Working Days Lost	0.6	6	1.5	0.7
Total staff employed in period (headcount)	14835	15528	15863	16245
Total staff employed with no absence (headcount)	13351	10093	12055	14458
Percentage of staff with no medical exclusion	90%	65%	76%	89%
Percentage of staff with no sick or medical exclusion	36%	33%	31%	26%

Medical exclusion adds a further 0.7 days on average per individual employee to overall absence. Overall average absence days lost per employee remains the same as 2021/22 however the days lost are lower in medical exclusion, resulting in a total of 314,656 total working days lost due to sickness absence and/or medical exclusion.

Staff Policies

Aneurin Bevan University Health Board has a range of staff policies in place, which are developed in partnership with staff and trade union colleagues. All policies are assessed via an Equality Impact Assessment to ensure that every policy is fair and does not inadvertently treat individuals or groups with a protected characteristic less favourably. This includes:

- giving full and fair consideration to applications for employment made by disabled persons or other protected characteristics, having regard to their particular aptitudes and abilities;
- continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- otherwise for the training, career development and promotion of disabled persons employed by the Health Board.

Between 01 April 2022 to 31 March 2023, one policy 'Accessing NHS Pension and Re-engagement Guidelines' was considered by the Remuneration and Terms of Service Committee. In addition, a new policy following advice and guidance on an all Wales basis in relation to pensions, i.e., Employer Pension Contributions Alternative Payment Policy, was considered by the Committee earlier in 2022 and applied from April 2022.

Employee Relations Matters

Details of the number of disciplinary cases between 01 March 2022 to 31 March 2023 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals
41	14	3	7

The above activity demonstrates over a 60% reduction in disciplinary cases compared to the previous twelve-month period.

Payment to Past Directors

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Expenditure on Consultancy	2022-23	
Note 3.3 from the main Accounts		
Consultant	**Details**	**£000**
Attain Health Management Services Ltd	Primary Community & MH - Strategic Capital Support - Phase 1	87
Castor Business Consulting Ltd	Consultancy Fees incurred re CCH PF	12
Deloitte LLP	Tax Advice	1
Ernst & Young LLP	VAT reviews re compliance	19
Figure & Consultancy Services Ltd	MH - Development, facilitation & implementation- fees incurred less than estimated in 2021	-8
Hugh Irwin Associates Ltd	Primary Community & MH - Strategic Capital Support - Phase 1	86
In-Form Solutions Ltd	Commercial Advice 2021-22 fees incurred less than estimated in 2021-22	-5
Oxford Brookes Enterprises Ltd	Primary Community & MH - Strategic Capital Support - Phase 1	7
Sirius Partners	Primary Community & MH - Strategic Capital Support - Phase 1	45
Supportive Care UK Ltd	Support to the specialist palliative care service	82
Synbiotix Solutions Ltd	Catering consultancy - to review output	1
TOTAL		327

Tax Assurance for Off-payroll Engagements

Table 1 : For all off-Payroll engagements as of 31 March 2023, for more than £245 per day

No. of exisiting Engagements as of 31 March 2022	5
Of which, the number that have existed:	
for less than one year at time of reporting	1
for between one and two years at time of reporting	2
for between two and three years at time of reporting	1
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

Table 2 : For all new off-Payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day

	Number
Number of new engagements between 1 April 2021 and 31 March 2022	3
Of which…	0
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Annex 1 (continued) Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	12

Exit Packages and Severance Payments

9.5 Reporting of other compensation schemes - exit packages					
	2022-23	2022-23	2022-23	2022-23	2021-22
Exit packages cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures**	**Total number of exit packages**	**Number of departures where special payments have been made**	Total number of exit packages
	Whole numbers only	**Whole numbers only**	**Whole numbers only**	**Whole numbers only**	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	1	1	0	2
£50,000 to £100,000	0	0	0	0	1
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	1	1	0	3

	2022-23	2022-23	2022-23	2022-23	2021-22
Exit packages cost band (including any special payment element)	**Cost of compulsory redundancies**	**Cost of other departures**	**Total cost of exit packages**	**Cost of special element included in exit packages**	Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	32,197	32,197	0	85,839
£50,000 to £100,000	0	0	0	0	76,771
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	32,197	32,197	0	162,610
Exit costs paid in year of departure			**Total paid in year**		Total paid in year
			2022-23		2021-22
			£		£
Exit costs paid in year			0		0
Total			0		0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has approved VERS in 2021/22.

Additional requirement as per FReM
£194,807 exit costs were paid in 2022-23, relating to 3 cases in 2021/22 and 1 case re 2022/23, the year of departure (£0 - 2021-22).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report

2022/23

Regularity of Expenditure
Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges
Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2022/23. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.421m for the provision of the statutory audit by the Wales Audit Office.

Managing public money
This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities

This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts. It relates to 11 medical negligence cases in 2022/23 (2 medical negligence cases and 1 personal injury case in 2021/22) and is reported in Note 21.2 to the main accounts.

The remote contingent liabilities cost consists of 11 medical negligence cases in 2022/23 (2 medical negligence cases and 1 personal injury case in 2021-22). Should these cases progress the majority of the costs incurred, in excess of the £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive **Date: XX July 2023**

THE CERTIFICATE AND INDEPENDENT AUDITOR'S REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

REPORT OF THE AUDITOR GENERAL TO THE SENEDD

Appendix One

Glossary

A		
ABUHB – Aneurin Bevan University Health Board	A&E – Accident & Emergency	ACV – Annual Contract Value
AGP – Aerosol Generating Procedures	AVLOS – Average Length of Stay	ABCHC – Aneurin Bevan Community Health Council
AMD – Age Related Macular Degeneration		
C		
CEO – Chief Executive Officer	CHC – Community Health Council	COSO - Committee of Sponsoring Organisations of the Treadway Commission
CBE – Commander of the Most Excellent Order of the British Empire	CYP – Children and Young People	CMO – Chief Medical Officer
COTE – Care of the Elderly	CONCCO –Concern - Expression of Patient Dissatisfaction (DATIX Coding)	CAD – Care After Death
CRL – Capital Resource Limit		
CCA – Civil Contingencies Act		
D		
DATIX – concerns / incident management system	DNA - Did Not Attend	DFL – Divisional Flu Lead
E		
EASC – Emergency Ambulance Services Committee	EMS - Environmental Management System	eLGH – Enhanced Local general Hospital
EoLC - End of Life Companions	ED – Emergency Department	EHEW - Eye Health Examination Wales
ESR – Electronic Staff Record	EOL – End of Life	

F		
FReM – Financial Reporting Manual		
G		
GMS – General Medical Services	GP – General Practitioner	GS – Governance Statement
GUH – Grange University Hospital	GDPR – General Data Protection Regulations	GDP – General Dental Practitioner
GARTH – Gwent Arts in Health	GAVO – Gwent Association of Voluntary Organisations	GDAS – Gwent Drug and Alcohol Service
GURT – Age simulation suit	GWICES – Gwent Wide Integrated Community Equipment Service	
H		
HPF – Healthcare Professionals Forum	HCSW – Health Care Support Worker	HM – Her Majesty's
HCS – Health and Care Standards	HEIW -Health Education and Improvement Wales	HCC - Hepato-Cellular Carcinoma
HEIW -Health Education and Improvement Wales	HCAI – Healthcare Associated Infection	HPV - Hydrogen Peroxide Vapour
HFrEF – Heart Failure with Reduced Ejection Fraction		
I		
IT – Information Technology	IMTP – Integrated Medium Term Plan	ICF – Integrated Care Fund
ISO – International Organisation for Standardisation	ICO – Information Commissioners Office	ICT – Information Communication Technology
IPBS- Intensive Positive Behavioural support	Iceberg–a visual representation of understanding the delivery of mental health services to children	IPC – Infection Prevention and Control
IFRS - International Financial Reporting Standards		
J		
JCVI – Joint Committee on Vaccination and Immunisation		
L		
LMC – Local Medical Committee	LHB – Local Health Board	LNC – Local Negotiating Committee

LES – Local Enhanced Service	LFD – Lateral Flow Device	LPS – Liberty Protection Safeguards
M		
MpMRI – multi-parametric magnetic resource imaging	MSK - Musculoskeletal	MDT – Multi Disciplinary Team
Myst – My Support team	MIU – Minor Injuries Unit	MAU – Medical Assessment Unit
MHLD – Mental Health and Learning Disabilities	MCA – Mental Capacity Act	MRSA - Methicillin Resistant Staphylococcus Aureus
MELO – Mental Health Resources Website		
N		
NCN – Neighbourhood Care Network	NHS – National Health Service	NEST - a strategic framework for the delivery of well being service for children – describing what all children need to thrive and what the systems around children also need. N- Nurture E-Empathy S – Support T – Trusted Adult.
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
OD – Organisational Development	OOH – Out of Hours	OAK - Options, Advice and Knowledge
OT – Occupational Therapy		
P		
PSB – Public Service Board	PQSOC – Patient Quality, Safety and Outcomes Committee	POCU – Post Operative Care Unit
PHW – Public Health Wales	PCR – Polymerase Chain Reaction	POCT – Point of Care Testing
PIFU - Patient Initiated Follow-ups	PROMS – Patient Reported Outcome Measures	PPE – Personal Protective Equipment

PWP - Psychological Wellbeing Practitioners	PCMHSS - Primary Care Mental Health Services	PREMS - Patient Reported Experience Measures
PoC – Proof of Concept	PLO – Patient Liaison Officer	PTR – Putting Things Right
PSOW – Public Services Ombudsman Wales	PA – Physician Associate	PADR – Personal Appraisal Development Review
PTSD – Post Traumatic Stress Disorder	PCC – Patient Centred Care	
R		
RGH – Royal Gwent Hospital	RCS – Royal College of Surgeons	RATS – Remuneration and Terms of Service Committee
RTT – Referral to Treatment	RPB – Regional Partnership Board	RIIV - Research, Improvement, Innovation and Value
RITA - Reminiscence Interactive Technology Assistance	RCP - Royal College of Physicians	RIF – Regional Integration Fund
S		
SIRO – Senior Information Risk Owner	SoS – See on Symptoms	SRG – Stakeholder Reference Group
SC2HU – Step Closer to Home Unit	SAR – Subject Access Request	SPACE - development of single point of access for children and young adults
SI – Serious Incident		
T		
TUPF – Trade Union Partnership Forum	TVA – Torfaen Voluntary Alliance	
U		
UPC - Urgent Primary Care	UDA - Units of Dental Activity	
V		
VERS – Voluntary Early Release Scheme	VBHC – Value Based Healthcare	
W		
WASPI - Wales Accord on the Sharing of Personal Information	WG – Welsh Government	WHC – Welsh Health Circular

WHSSC – Welsh Health Specialised Services Committee	WPAS - Welsh Patient Administration System	WTE – Whole Time Equivalent
WHO – World Health Organisation		
Y		
YAB – Ysbyty Aneurin Bevan	YYF – Ysbyty Ystrad Fawr	

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 July 2023
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Aneurin Bevan University Health Board Final Accounts for 2022/23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Ross, Assistant Director of Finance (Financial Systems and Services)

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

To give assurance to the Committee along with the Head of Internal Audit Opinion and the Audit Wales audit of annual accounts report, to enable the Committee to recommend that the Board approve the ABUHB 2022/23 accounts.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The accounts for 2022/23 are attached to this paper.

There have been no changes from the draft accounts that affect performance against any of the Health Board's duties reported to the Committee on the 23rd of May.

Audit Wales have confirmed they intend to give an unqualified opinion on the Aneurin Bevan University Health Board 2022/23 Financial Statements.

A number of classification type adjustments have been made during the audit. These are included in Appendix 1 attached. None of the adjustments have any impact on the financial targets.

The Committee are asked to note that the accounts have been satisfactorily completed, and along with the audit of annual accounts report from Audit Wales and the Head of Internal Audit Opinion, recommend approval of the Accounts by the Board at the meeting on 19th July.

At the time of writing this report there are still some minor audit queries outstanding, with Audit Wales also carrying out a final review of the audit. A further update on the outstanding queries will be presented at the meeting.
Cefndir / Background See above.
Asesiad / Assessment This report provides the Committee with details of amendments actioned from the draft accounts to the final accounts on completion of the Audit, providing confirmation that none of the above have impacted the 2022/23 reported position of the Health Board. At the time of writing, Audit Wales are following up a number of minor queries - an update will be provided at the Committee. At the Committee meeting held on the 23rd of May, more information was requested on the decrease in expenditure for voluntary organisations and the impact on voluntary organisations that support the Health Board. Appendix 2 gives more detail on this movement between years.
Argymhelliad / Recommendation The Audit, Risk & Assurance Committee is asked to endorse the Aneurin Bevan University Health Board accounts for 2022/23 for approval by the Board on 19th July 2023.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	ICF - Intermediate Care Fund
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

2022/23 ANNUAL ACCOUNTS – Appendix 1

Adjustments Actioned from Draft to Final 2022/23 Annual Accounts

Note No.	Issue	Impact On Fin. Target
	ADJUSTMENTS ACTIONED	
3.3/4/9.1	Increase in operational staff costs due to a coding correction relating to two Swansea Bay invoices coded to income in error in draft. Note 3.3 - Operational Staff Costs - expenditure increased by £89K. Note 4 - Local Health Boards - income increased by £89K. Note 9.1 - Salaries and wages - permanent staff- costs increased by £89K.	None
3.4	Permanent injury included within personal injury amount of £285,049 incorrectly entered.	None
4	Rental income from operating leases line/value not populated in draft – shown in other income. Amended to reflect £226K in correct line and reduce other income by £226K and associated footnote.	None
9.2	SLE staffing numbers double counted in draft, shown within seconded in and SLE in error. Seconded figure reduced by 392 in final accounts and Nursing Midwifery increased by £1 to reflect correct rounded figure.	None
11.1	Fully depreciated assets with a GBV of £975K were disposed of during the year which were subsequently verified as still in existence, therefore the disposals were reversed.	None
Other	Amendments to some of the footnotes to reflect the correct case numbers or to add in case numbers where they have been omitted in the draft. Additional narrative added re • not achieving breakeven. • remote contingent liability cases and the funding mechanism should they materialise in the future. • 2022/23 recovery payment	None
LFRs LFR101 LFR3 LFR6 LFR9	LFRs amended to account for the adjustments within the main accounts	None
	REMUNERATION REPORT & PENSIONS BENEFITS	
	Added sentence added re secondment of Andrew Goodall and Judith Paget for 2022/23 and 2021/22 re secondment start date and bandings	None
	Rhiannon Jones – Amendment to pension benefits.	None

	Peter Carr – benefit in kind increased.	None
	Sarah Simmonds – Benefit in Kind added	None
	Linda Alexander - employees' pension contribution reduced.	None

Appendix 2

Draft Annual Accounts query re Voluntary Organisations.

The following detail was provided in the draft accounts in relation to the reduction in spend with voluntary organisations:

"Voluntary Organisations
A decrease in expenditure of £9.6m
This mainly relates to the legacy Intermediate Care Fund (ICF) programme managed funds where voluntary partner organisations expended more in 2021/22 compared to 2022/23 as projects were delivered.

In addition to this, the funding mechanism for ICF in 2021/22 changed to the HCF (Housing with Care Fund) in 2022/23, which meant that most of the funding which was previously provided to the health board to distribute is now allocated directly to delivery partners."

The table below provides more detail on the reduction in spend £9.06m, relating to the Intermediate Care fund which accounts for the majority of the reduction of £9.6m due to the change in funding mechanism in 2022/23.

58510-Service Level Agreement - Voluntary Body for RPB Related Spend Reconciliation	21/22 Spend	22/23 Spend	Variance
	£	£	£
ICF/HCF Schemes for Voluntary Sector Organisation including Housing Associations (Capital related Schemes where funding is awarded directly to the delivery organisation from 22/23)	7,101,208	598,534	-6,502,674
ICF/HCF Schemes for Voluntary Sector Organisations (Revenue Related Schemes where £1.7m of 22/23 spend was omitted from the initial query)	2,605,468	2,104,159	-501,309
ICF/RIF Winter/slippage Schemes for Voluntary Sector Organisations where £1.2m was incorrectly coded in 21/22 and not re-coded in 22/23. Slippages and Winter schemes in 22/23 was managed on a more strategic level through the RPB.	1,826,446	-230,494	-2,056,940
58510-Service Level Agreement - Voluntary Body for RPB Related Spend	**11,533,122**	**2,472,199**	**-9,060,923**

In 2021/22 the health board were awarded and managed the ICF/HCF funding but from 2022/23 onwards the funding is awarded direct to the delivery organisation which also impacts the level of spend within the Health Board.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

The Local Health Board was established on 1st October 2009 following the merger of Gwent Healthcare NHS Trust and the following Local Health Boards.
Blaenau Gwent Local Health Board
Caerphilly Local Health Board
Monmouthshire Local Health Board
Newport Local Health Board
Torfaen Local Health Board

The Health Board covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a population of approximately 600,000 people. The Health Board has an annual budget from the Welsh Government of just over £1.6 billion per year from which we plan and deliver services for the population of the Health Board area. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being Act and the Well Being of Future Generations Act.

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2021-22. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the Primary Statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the LHB which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1 April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2023

	Note	2022-23 £000	2021-22 £000
Expenditure on Primary Healthcare Services	3.1	**307,116**	293,748
Expenditure on healthcare from other providers	3.2	**474,153**	463,401
Expenditure on Hospital and Community Health Services	3.3	**1,004,067**	950,978
		1,785,336	1,708,127
Less: Miscellaneous Income	4	**(109,566)**	(109,638)
LHB net operating costs before interest and other gains and losses		**1,675,770**	1,598,489
Investment Revenue	5	**(18)**	(16)
Other (Gains) / Losses	6	**(530)**	(232)
Finance costs	7	**1,060**	562
Net operating costs for the financial year		**1,676,282**	**1,598,803**

See note 2 on page 28 for details of performance against Revenue and Capital allocations.

The notes on pages 8 to 76 form part of these accounts.

Other Comprehensive Net Expenditure

	2022-23 £000	2021-22 £000
Net (gain) / loss on revaluation of property, plant and equipment	**(47,165)**	(9,960)
Net (gain)/loss on revaluation of right of use assets	**(17)**	
Net (gain) / loss on revaluation of intangibles	**0**	0
(Gain) / loss on other reserves	**0**	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	**0**	0
Net (gain)/loss on revaluation of financial assets held for sale	**0**	0
Impairment and reversals	**0**	0
Transfers between reserves	**0**	0
Transfers to / (from) other bodies within the Resource Accounting Boundary	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Other comprehensive net expenditure for the year	**(47,182)**	(9,960)
Total comprehensive net expenditure for the year	**1,629,100**	1,588,843

The notes on pages 8 to 76 form part of these accounts.

Statement of Financial Position as at 31 March 2023

	Notes	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment	11	**869,541**	810,479
Right of Use Assets	11.3	**23,867**	
Intangible assets	12	**5,091**	5,211
Trade and other receivables	15	**77,466**	125,697
Other financial assets	16	**726**	521
Total non-current assets		**976,691**	941,908
Current assets			
Inventories	14	**9,576**	8,726
Trade and other receivables	15	**152,162**	133,774
Other financial assets	16	**58**	33
Cash and cash equivalents	17	**4,704**	1,720
		166,500	144,253
Non-current assets classified as "Held for Sale"	11	**0**	0
Total current assets		**166,500**	144,253
Total assets		**1,143,191**	1,086,161
Current liabilities			
Trade and other payables	18	**(222,124)**	(223,290)
Other financial liabilities	19	**0**	0
Provisions	20	**(87,280)**	(63,283)
Total current liabilities		**(309,404)**	(286,573)
Net current assets/ (liabilities)		**(142,904)**	(142,320)
Non-current liabilities			
Trade and other payables	18	**(20,692)**	(3,709)
Other financial liabilities	19	**0**	0
Provisions	20	**(81,186)**	(132,424)
Total non-current liabilities		**(101,878)**	(136,133)
Total assets employed		**731,909**	663,455
Financed by :			
Taxpayers' equity			
General Fund		**552,847**	530,429
Revaluation reserve		**179,062**	133,026
Total taxpayers' equity		**731,909**	663,455

The financial statements on pages 2 to 7 were approved by the Board on 19 July 2023 and signed on its behalf by:

Chief Executive and Accountable Officer …….. Date: 19 July 2023

The notes on pages 8 to 76 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2023

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2022-23			
Balance as at 31 March 2022	530,429	133,026	**663,455**
NHS Wales Transfer	1,106	0	**1,106**
RoU Asset Transitioning Adjustment	820	0	**820**
Balance at 1 April 2022	532,355	133,026	**665,381**
Net operating cost for the year	(1,676,282)		**(1,676,282)**
Net gain/(loss) on revaluation of property, plant and equipment	0	47,165	**47,165**
Net gain/(loss) on revaluation of right of use assets	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other Reserve Movement	0	0	**0**
Transfers between reserves	1,129	(1,129)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2022-23	(1,675,153)	46,036	**(1,629,117)**
Net Welsh Government funding	1,667,210		**1,667,210**
Notional Welsh Government Funding	28,435		**28,435**
Balance at 31 March 2023	552,847	179,062	**731,909**

The notes on pages 8 to 76 form part of these accounts.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2022

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2021-22			
Balance at 31 March 2021	512,572	124,005	**636,577**
NHS Wales Transfer	0	0	**0**
RoU Asset Transitioning Adjustment			
Balance at 1 April 2021	512,572	124,005	**636,577**
Net operating cost for the year	(1,598,803)		**(1,598,803)**
Net gain/(loss) on revaluation of property, plant and equipment	0	9,960	**9,960**
Net gain/(loss) on revaluation of right of use assets			
Net gain/(loss) on revaluation of intangible assets	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	**0**
Net gain/(loss) on revaluation of assets held for sale	0	0	**0**
Impairments and reversals	0	0	**0**
Other reserve movement	0	0	**0**
Transfers between reserves	939	(939)	**0**
Release of reserves to SoCNE	0	0	**0**
Transfers to/from LHBs	0	0	**0**
Total recognised income and expense for 2021-22	(1,597,864)	9,021	**(1,588,843)**
Net Welsh Government funding	1,588,806		**1,588,806**
Notional Welsh Government Funding	26,915		**26,915**
Balance at 31 March 2022	530,429	133,026	**663,455**

The notes on pages 8 to 76 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2023

	Notes	2022-23 £000	2021-22 £000
Cash Flows from operating activities			
Net operating cost for the financial year		**(1,676,282)**	(1,598,803)
Movements in Working Capital	27	**26,776**	(20,952)
Other cash flow adjustments	28	**46,683**	92,791
Provisions utilised	20	**(15,442)**	(10,474)
Net cash outflow from operating activities		**(1,618,265)**	(1,537,438)
Cash Flows from investing activities			
Purchase of property, plant and equipment		**(39,158)**	(52,999)
Proceeds from disposal of property, plant and equipment		**591**	3,347
Purchase of intangible assets		**(1,932)**	(930)
Proceeds from disposal of intangible assets		**0**	0
Payment for other financial assets		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Payment for other assets		**0**	0
Proceeds from disposal of other assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(40,499)**	(50,582)
Net cash inflow/(outflow) before financing		**(1,658,764)**	(1,588,020)
Cash Flows from financing activities			
Welsh Government funding (including capital)		**1,667,210**	1,588,806
Capital receipts surrendered		**0**	0
Capital grants received		**62**	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes		**0**	(887)
Capital element of payments in respect of on-SoFP PFI		**(947)**	0
Capital element of payments in respect of Right of Use Assets		**(4,577)**	
Cash transferred (to)/ from other NHS bodies		**0**	0
Net financing		**1,661,748**	1,587,919
Net increase/(decrease) in cash and cash equivalents		**2,984**	(101)
Cash and cash equivalents (and bank overdrafts) at 1 April 2022		**1,720**	1,821
Cash and cash equivalents (and bank overdrafts) at 31 March 2023		**4,704**	1,720

The notes on pages 8 to 76 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHB) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2022-23 Manual for Accounts. The accounting policies contained in that manual follow the 2022-23 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FREM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-20 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, in Wales the additional 6.3% being funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency).

However, NHS Wales' organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Note 34 within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCNE. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This dictates that to ensure that asset carrying values are not materially overstated. For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use.

● the intention to complete the intangible asset and use it.

● the ability to use the intangible asset.

● how the intangible asset will generate probable future economic benefits.

● the availability of adequate technical, financial and other resources to complete the intangible asset and use it.

● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale, within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.
The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16.
Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.
There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The entity will not apply IFRS 16 to any new leases of in tangible assets applying the treatment described in section 1.14 instead.

On componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The LHB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 The LHB as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHBs net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the LHBs net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2022-23 and 2021-22. The WRP is hosted by Velindre NHS University Trust.

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the LHB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in Note 31 to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budget

The LHB has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one organisation. Payments for services provided are accounted for as miscellaneous income. The LHB accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit
Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising **72%** of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent - Gwent Wide Integrated Community Equipment Service
Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts

Monmouthshire County Council - Mardy Park Rehabilitation Centre
Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent - Gwent Frailty Programme
Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council , as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People
Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -
• To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.
• To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund
• To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty
In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.
The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1 April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels. Changes associated with these liabilities are adjusted in the following reporting period.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.
Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the LHB, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
	Contingent Liability for all other estimated expenditure.	
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

* *Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of minus 0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £162m (£188m 2021/22) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of 0.427m (£0.495m 2021/22) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provsions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2021) Post Employment Benefits Liabilities Real Rate in Exccess of CPI of 1.70%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Wales organisation therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the NHS Wales organisation's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.2. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.3. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Wales organisation's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.4. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHBs SoFP.

1.26.5. Other assets contributed by the LHB operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the LHB through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position
Where the LHB has no control or residual interest in the assets and the balance of risks and rewards lie with the operator, the arrangement is treated as an operating lease and the costs are included in the SoCNE as incurred. The LHB has one such arrangement relating to the maintenance of the energy systems in Nevill Hall Hospitals.

Joint PFI contract
The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM

IFRS14 Regulatory Deferral Accounts
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.30. Accounting standards issued that have been adopted early

During 2022-23 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary and therefore is required to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB.

However, the LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate. Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties' notes.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1 April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1 April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

Annual financial performance

	2020-21	2021-22	2022-23	**Total**
	£000	£000	£000	**£000**
Net operating costs for the year	1,551,819	1,598,803	1,676,282	**4,826,904**
Less general ophthalmic services expenditure and other non-cash limited expenditure	(1,423)	(58)	148	**(1,333)**
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	0	0	0	**0**
Less unfunded revenue consequences of bringing RoU Leases onto SoFP	0	0	0	**0**
Total operating expenses	1,550,396	1,598,745	1,676,430	**4,825,571**
Revenue Resource Allocation	1,550,641	1,598,994	1,639,588	**4,789,223**
Under /(over) spend against Allocation	245	249	(36,842)	**(36,348)**

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2020-21 to 2022-23. The Health Board will, in dialogue with Welsh Government, confirm the implications for reporting this deficit as part of the 2023/24 IMTP.

The health board received £23m of strategic cash support in 2022-23.

2.2 Capital Resource Performance

	2020-21	2021-22	2022-23	**Total**
	£000	£000	£000	**£000**
Gross capital expenditure	112,376	52,167	41,028	**205,571**
Add: Losses on disposal of donated assets	0	0	2	**2**
Less NBV of property, plant and equipment and intangible assets disposed	(884)	(3,115)	(61)	**(4,060)**
Less capital grants received	(333)	(22)	(62)	**(417)**
Less donations received	(201)	(166)	(227)	**(594)**
Less IFRS16 Peppercorn income	0	0	0	**0**
Less initial recognition of RoU Asset Dilapidations	0	0	0	**0**
Add: recognition of RoU Assets Dilapidations on crystallisation	0	0	0	**0**
Charge against Capital Resource Allocation	110,958	48,864	40,680	**200,502**
Capital Resource Allocation	110,971	48,914	40,723	**200,608**
(Over) / Underspend against Capital Resource Allocation	13	50	43	**106**

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2020-21 to 2022-23.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2022-2025 issued to LHBs placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The LHB submitted an Integrated Medium Term Plan for the period 2022-2025 in accordance with NHS Wales Planning Framework.

The Minister for Health and Social Services extant approval

Status	**Approved**
Date	13/07/2022

The LHB has therefore met its statutory duty to have an approved Integrated Medium Term plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2022-23	2021-22
Total number of non-NHS bills paid	**371,943**	322,710
Total number of non-NHS bills paid within target	**354,020**	306,680
Percentage of non-NHS bills paid within target	95.2%	95.0%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2022-23 Total £000	2021-22 Total £000
General Medical Services	116,217		116,217	112,524
Pharmaceutical Services	31,959	(6,686)	25,273	25,082
General Dental Services	39,817		39,817	38,030
General Ophthalmic Services	2,328	6,538	8,866	9,343
Other Primary Health Care expenditure	2,612		2,612	2,487
Prescribed drugs and appliances	114,331		114,331	106,282
Total	**307,264**	**(148)**	**307,116**	293,748

Note 3.1 - Expenditure on Primary Healthcare Services
The General Medical Services expenditure includes £16,406k (2021/22 £12,860k) in relation to staff salaries, the General Dental Services expenditure includes £3,032k (2021/22 £1,732k) in relation to staff salaries, the Prescribed Drugs & Appliance expenditure includes £329k (2021/22 £334k) in relation to staff salaries, and the General Ophthalmic Services includes £8k (2021/22 £10k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2022-23 £000	2021-22 £000
Goods and services from other NHS Wales Health Boards	**63,968**	62,504
Goods and services from other NHS Wales Trusts	**43,527**	45,812
Goods and services from Welsh Special Health Authorities	**0**	0
Goods and services from other non Welsh NHS bodies	**10,092**	9,321
Goods and services from WHSSC / EASC	**198,320**	177,035
Local Authorities	**47,685**	50,403
Voluntary organisations	**9,260**	18,825
NHS Funded Nursing Care	**9,681**	9,157
Continuing Care	**86,006**	83,675
Private providers	**5,392**	6,535
Specific projects funded by the Welsh Government	**0**	0
Other	**222**	134
Total	474,153	463,401

Local Authorities expenditure relates to the following bodies:	**£'000**	£'000
Blaenau Gwenty County Borough Council	**4,331**	**5,048**
Caerphilly County Borough Council	**17,867**	**19,080**
Monmouthshire County Council	**8,334**	**5,531**
Newport City Council	**10,252**	**12,204**
Torfaen County Borough Council	**6,790**	**8,460**
Gloucestershire County Council	**111**	**21**
Vale of Glamorgan Council	**0**	**58**
Swindon Borough Council	**0**	**1**
	47,685	50,403

3.3 Expenditure on Hospital and Community Health Services

	2022-23	2021-22
	£000	£000
Directors' costs	2,374	2,243
Operational Staff costs	729,603	695,903
Single lead employer Staff Trainee Cost	30,104	16,109
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	120,657	116,736
Supplies and services - general	20,123	21,699
Consultancy Services	327	175
Establishment	6,928	8,101
Transport	1,942	2,257
Premises	48,310	42,463
External Contractors	0	0
Depreciation	42,936	41,158
Depreciation (Right of Use assets RoU)	4,479	
Amortisation	2,859	2,517
Fixed asset impairments and reversals (Property, plant & equipment)	(19,470)	(12,619)
Fixed asset impairments and reversals (RoU Assets)	0	
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	421	396
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	1,526	2,831
Research and Development	0	0
Expense related to short-term leases	552	
Expense related to low-value asset leases (excluding short-term leases)	858	
Other operating expenses	9,538	11,009
Total	**1,004,067**	950,978

The Health Board spent 2.7m (£2.2m 2021/22) on Research and Development. The majority of this spend relates to staff £2.2M (£2.1m 2021/22) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2022-23 Research and Development income received was £2.6m including £1.6m received from Welsh Government.

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2022-23	2021-22
Increase/(decrease) in provision for future payments:	£000	£000
Clinical negligence;		
Secondary care	(3,578)	39,857
Primary care	38	84
Redress Secondary Care	478	185
Redress Primary Care	0	0
Personal injury	193	1,441
All other losses and special payments	34	665
Defence legal fees and other administrative costs	1,184	1,259
Gross increase/(decrease) in provision for future payments	(1,651)	**43,491**
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	(104)	(65)
Less: income received/due from Welsh Risk Pool	3,281	(40,595)
Total	**1,526**	2,831

	2022-23	2021-22
	£	£
Permanent injury included within personal injury	(285,049)	208,625

Note 3.4 includes £615,848 (£510,040 2021/22) relating to Redress cases which represents 81 (66 2021/22) cases where payments were made in year totalling £275,664 (£383,813 2021/22) including defence fees. An additional provision has been created for a further 50 (20 2021/22) cases where an offer has been made or causation and breach have been proven with estimated costs of £340,184 (£126,227 2021/22).

Note 3.3 includes a credit relating to reversals of impairment of fixed assets. This is primarily as a result of the 2022-23 Quinquennial revaluations of land and buildings. Further to the revaluations, indexation was applied during 2022-23 using rates provided by the District Valuation Office. Land rates fell by 4 percentage points and buildings rose by 4.75 percentage points. The detailed figures can be found in note 13.

4. Miscellaneous Income

	2022-23 £000	2021-22 £000
Local Health Boards	20,509	21,743
Welsh Health Specialised Services Committee (WHSSC)/Emergency Ambulance Services Committee (EASC)	11,521	9,772
NHS Wales trusts	10,652	9,626
Welsh Special Health Authorities	13,782	12,313
Foundation Trusts	22	9
Other NHS England bodies	1,469	1,441
Other NHS Bodies	58	36
Local authorities	19,078	20,520
Welsh Government	4,622	8,060
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	0	0
Dental fee income	4,848	3,463
Private patient income	27	(3)
Overseas patients (non-reciprocal)	42	16
Injury Costs Recovery (ICR) Scheme	1,022	986
Other income from activities	837	822
Patient transport services	0	0
Education, training and research	2,043	4,088
Charitable and other contributions to expenditure	1,048	930
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	210	166
Receipt of Government granted assets	62	22
Right of Use Grant (Peppercorn Lease)	17	
Non-patient care income generation schemes	100	112
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Right of Use Asset Sub-leasing rental income	0	
Contingent rental income from finance leases	0	0
Rental income from operating leases	226	0
Other income:		
Provision of laundry, pathology, payroll services	102	73
Accommodation and catering charges	3,103	2,194
Mortuary fees	375	285
Staff payments for use of cars	617	682
Business Unit	0	0
Scheme Pays Reimbursement Notional	(615)	756
Other	13,789	11,526
Total	**109,566**	109,638

Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	4,265	3,193
VAT recoveries re Business Activities and Contracted Out Services	1,523	2,011
Integrated Care Fund	4,894	2,164
Other	3,107	4,158
Total	**13,789**	11,526

Injury Cost Recovery (ICR) Scheme income

	2022-23 %	2021-22 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.86	23.76

5. Investment Revenue

	2022-23	2021-22
	£000	£000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	18	16
Total	18	16

6. Other gains and losses

	2022-23	2021-22
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	530	237
Gain/(loss) on disposal of intangible assets	0	(32)
Gain/(loss) on disposal of assets held for sale	0	27
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	530	232

7. Finance costs

	2022-23	2021-22
	£000	£000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	2
Interest on obligations under Right of Use Leases	232	
Interest on obligations under PFI contracts;		
main finance cost	239	269
contingent finance cost	471	387
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	942	658
Provisions unwinding of discount	118	(96)
Other finance costs	0	0
Total	1,060	562

8. Future change to SoCNE/Operating Leases

LHB as lessee

As at 31st March 2023 the LHB had 2 operating leases agreements in place for the lease of premises, 554 arrangements in respect of equipment and 206 in respect of vehicles with 3 property, 122 equipment and 130 vehicle leases having expired in year.

	Post Implementation of IFRS 16		Pre implementation of IFRS 16
	Low Value & Short Term	**Other**	
Payments recognised as an expense	**2022-23**	**2022-23**	2021-22
	£000	**£000**	£000
Minimum lease payments	**1,487**	**0**	6,245
Contingent rents	**0**	**0**	0
Sub-lease payments	**0**	**0**	0
Total	**1,487**	**0**	6,245

Total future minimum lease payments			
Payable	**£000**	**£000**	£000
Not later than one year	**864**	**0**	4,358
Between one and five years	**612**	**0**	10,468
After 5 years	**0**	**0**	8,847
Total	**1,476**	**0**	23,673

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only. Previously reported Expenditure £4,895k and Minimum lease Payments £21,634k transitioned to the balance sheet as right of use assets.

LHB as lessor

	Post Implementation of IFRS 16	Pre implementation of IFRS 16
Rental revenue	**£000**	£000
Rent	**226**	196
Contingent rents	**0**	0
Total revenue rental	**226**	196

Total future minimum lease payments		
Receivable	**£000**	£000
Not later than one year	**252**	192
Between one and five years	**964**	739
After 5 years	**1,236**	844
Total	**2,452**	1,775

9. Employee benefits and staff numbers

9.1 Employee costs

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2021-22
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	539,172	1,964	57,339	24,987	0	3,547	627,009	586,999
Social security costs	59,244	0	0	3,005	0	0	62,249	54,686
Employer contributions to NHS Pension Scheme	90,084	0	0	3,160	0	0	93,244	88,348
Other pension costs	365	0	0	0	0	0	365	123
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	688,865	1,964	57,339	31,152	0	3,547	782,867	730,156

Charged to capital	1,011	964
Charged to revenue	781,856	729,192
	782,867	730,156
Net movement in accrued employee benefits (untaken staff leave)	(12)	2,571
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		2,474
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave		97

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

The net movement in COVID annual leave was a release of £16.243m in year, which included a release of £1.049m in relation to Specialist Trainees.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2021-22
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,677	20	30	0	0	0	2,727	2,582
Medical and dental	758	6	82	393	0	20	1,259	1,234
Nursing, midwifery registered	3,736	7	248	0	0	0	3,991	4,051
Professional, Scientific, and technical staff	460	0	2	0	0	0	462	436
Additional Clinical Services	2,668	0	209	0	0	0	2,877	2,792
Allied Health Professions	802	0	27	0	0	0	829	804
Healthcare Scientists	230	4	11	0	0	0	245	243
Estates and Ancilliary	975	0	171	0	0	0	1,146	1,145
Students	10	0	0	0	0	0	10	4
Total	12,316	37	780	393	0	20	13,546	13,291

9.3. Retirements due to ill-health

	2022-23	2021-22
Number	14	2
Estimated additional pension costs £	606,310	74,988

The estimated additional pension costs of these ill-health retirements have been calculated on an average basis and are borne by the NHS Pension Scheme.

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2022-23 Number of compulsory redundancies	2022-23 Number of other departures	2022-23 Total number of exit packages	2022-23 Number of departures where special payments have been made	2021-22 Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	1	1	0	2
£50,000 to £100,000	0	0	0	0	1
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	1	1	0	3

Exit packages cost band (including any special payment element)	2022-23 Cost of compulsory redundancies	2022-23 Cost of other departures	2022-23 Total cost of exit packages	2022-23 Cost of special element included in exit packages	2021-22 Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	32,197	32,197	0	85,839
£50,000 to £100,000	0	0	0	0	76,771
£100,000 to £150,000	0	0	0	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	32,197	32,197	0	162,610

Exit costs paid in year of departure	Total paid in year 2022-23	Total paid in year 2021-22
	£	£
Exit costs paid in year	0	0
Total	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS). Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The Health Board has approved VERS in 2022/23.

Additional requirement as per FReM
£194,807 exit costs were paid in 2022-23, relating to 3 cases in 2021/22 and 1 case re 2022/23, the year of departure (£0 - 2021-22).

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director /employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2022-23	2022-23	2022-23	2021-22	2021-22	2021-22
	£000	£000	£000	£000	£000	£000
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**215 - 220**	**26**	**8.3**	200 - 205	25	8.1
Median pay	**215 - 220**	**33**	**6.5**	200 - 205	32	6.3
75th percentile pay ratio	**215 - 220**	**43**	**5.0**	200 - 205	42	4.8
Salary component of total pay and benefits						
25th percentile pay ratio	**215 - 220**	**26**		200 - 205	25	
Median pay	**215 - 220**	**33**		200 - 205	32	
75th percentile pay ratio	**215 - 220**	**43**		200 - 205	42	

	Highest Paid			Highest Paid		
Total pay and benefits	**Director**	**Employee**	**Ratio**	Director	Employee	Ratio
25th percentile pay ratio	**215 - 220**	**26**	**8.3**	200 - 205	25	8.1
Median pay	**215 - 220**	**33**	**6.5**	200 - 205	32	6.3
75th percentile pay ratio	**215 - 220**	**43**	**5.0**	200 - 205	42	4.8
Salary component of total pay and benefits						
25th percentile pay ratio	**215 - 220**	**26**		200 - 205	25	
Median pay	**215 - 220**	**33**		200 - 205	32	
75th percentile pay ratio	**215 - 220**	**43**		200 - 205	42	

In 2022-23, 15 (2021-22, 7) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £14k to £416k (2021-22, £19k to £338k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial year summary

There has been an increase in the pay ratio which attributable to the increase in the chief exectuive / highest paid director salary being greater than the increase in the employee median salary.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the enti ty's employees taken as a whole.

9.6.2 Percentage Changes	**2021-22 to 2022-23**	2020-21 to 2021-22
% Change from previous financial year in respect of Chief Executive	**%**	**%**
Salary and allowances	**7**	(2)
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	**7**	(2)
Performance pay and bonuses	**0**	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	**5**	**5**
Performance pay and bonuses	**0**	**0**

9.7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2022-2023 tax year (2021-2022 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2022-23	**2022-23**	2021-22	2021-22
NHS	**Number**	**£000**	Number	£000
Total bills paid	4,740	380,000	4,776	342,787
Total bills paid within target	4,198	360,894	4,154	328,582
Percentage of bills paid within target	**88.6%**	**95.0%**	87.0%	95.9%
Non-NHS				
Total bills paid	371,943	651,605	322,710	632,798
Total bills paid within target	354,020	624,146	306,680	603,323
Percentage of bills paid within target	**95.2%**	**95.8%**	95.0%	95.3%
Total				
Total bills paid	**376,683**	**1,031,605**	327,486	975,585
Total bills paid within target	**358,218**	**985,040**	310,834	931,905
Percentage of bills paid within target	**95.1%**	**95.5%**	94.9%	95.5%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23	2021-22
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**413**	77
Total	**413**	**77**

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost at 31 March bf	78,456	691,679	3,030	23,203	130,298	546	39,785	4,184	971,181
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	(32)	(392)	0	0	0	0	(517)	0	(941)
Cost or valuation at 1 April 2022	**78,424**	**691,287**	**3,030**	**23,203**	**130,298**	**546**	**39,268**	**4,184**	**970,240**
Indexation	(2,002)	16,637	22	0	0	0	0	0	14,657
Additions									
- purchased	0	4,259	53	22,262	4,961	0	4,937	112	36,584
- donated	0	0	0	0	109	0	63	38	210
- government granted	0	44	0	0	18	0	0	0	62
Transfer from/into other NHS bodies	0	0	0	0	1,106	0	0	0	1,106
Reclassifications	0	6,811	0	(8,529)	(56)	0	46	10	(1,718)
Revaluations	3,694	(26,767)	(715)	0	0	0	0	0	(23,788)
Reversal of impairments	0	8,529	(153)	0	0	0	0	0	8,376
Impairments	(2,608)	(4,604)	0	0	0	0	0	0	(7,212)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(18,246)	0	(1,004)	(182)	(19,432)
At 31 March 2023	**77,508**	**696,196**	**2,237**	**36,936**	**118,190**	**546**	**43,310**	**4,162**	**979,085**
Depreciation at 31 March bf	0	74,177	415	0	66,042	470	18,529	1,069	**160,702**
NHS Wales Transfers	0	0	0	0	0	0	0	0	**0**
Transfer of Finance Leases to ROU Asset Note	0	(108)	0	0	0	0	(13)	0	**(121)**
Depreciation at 1 April 2022	**0**	**74,069**	**415**	**0**	**66,042**	**470**	**18,516**	**1,069**	**160,581**
Indexation	0	53	0	0	0	0	0	0	**53**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	(10)	0	7	3	**0**
Revaluations	0	(56,103)	(246)	0	0	0	0	0	**(56,349)**
Reversal of impairments	0	(17,935)	(168)	0	0	0	0	0	**(18,103)**
Impairments	0	(203)	0	0	0	0	0	0	**(203)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	0	(18,185)	0	(1,004)	(182)	**(19,371)**
Provided during the year	0	22,241	293	0	13,152	32	6,805	413	**42,936**
At 31 March 2023	**0**	**22,122**	**294**	**0**	**60,999**	**502**	**24,324**	**1,303**	**109,544**
Net book value at 1 April 2022	**78,424**	**617,218**	**2,615**	**23,203**	**64,256**	**76**	**20,752**	**3,115**	**809,659**
Net book value at 31 March 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**
Net book value at 31 March 2023 comprises :									
Purchased	74,353	672,131	1,943	36,936	56,328	44	18,905	2,809	**863,449**
Donated	3,155	1,746	0	0	608	0	81	50	**5,640**
Government Granted	0	197	0	0	255	0	0	0	**452**
At 31 March 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**
Asset financing :									
Owned	77,508	668,777	1,943	36,936	57,049	44	18,986	2,859	**864,102**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts	0	5,297	0	0	142	0	0	0	**5,439**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
At 31 March 2023	**77,508**	**674,074**	**1,943**	**36,936**	**57,191**	**44**	**18,986**	**2,859**	**869,541**

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000
Freehold	748,040
Long Leasehold	5,410
Short Leasehold	75
	753,525

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. **0**

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	**Total £000**
Cost or valuation at 1 April 2021	76,903	643,590	2,783	23,260	124,444	548	36,112	4,867	912,507
Indexation	1,486	9,910	67	0	0	0	0	0	11,463
Additions									
- purchased	0	9,173	115	17,912	15,831	0	7,286	497	50,814
- donated	0	0	0	0	152	0	14	0	166
- government granted	0	0	0	0	22	0	0	0	22
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	17,726	0	(17,798)	0	0	72	0	0
Revaluations	0	(668)	0	0	0	0	0	0	(668)
Reversal of impairments	67	20,451	65	0	0	0	0	0	20,583
Impairments	0	(8,503)	0	(171)	0	0	0	0	(8,674)
Reclassified as held for sale	0	0	0	0	(91)	0	0	0	(91)
Disposals	0	0	0	0	(10,060)	(2)	(3,699)	(1,180)	(14,941)
At 31 March 2022	78,456	691,679	3,030	23,203	130,298	546	39,785	4,184	971,181
Depreciation at 1 April 2021	0	51,563	314	0	62,413	439	16,061	1,782	132,572
Indexation	0	1,508	8	0	0	0	0	0	1,516
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	(681)	0	0	0	0	0	0	(681)
Reversal of impairments	0	684	6	0	0	0	0	0	690
Impairments	0	(1,400)	0	0	0	0	0	0	(1,400)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(8,355)	(2)	(3,616)	(1,180)	(13,153)
Provided during the year	0	22,503	87	0	11,984	33	6,084	467	41,158
At 31 March 2022	0	74,177	415	0	66,042	470	18,529	1,069	160,702
Net book value at 1 April 2021	76,903	592,027	2,469	23,260	62,031	109	20,051	3,085	779,935
Net book value at 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479
Net book value at 31 March 2022 comprises :									
Purchased	75,349	615,715	2,615	23,203	63,317	76	21,228	3,095	804,598
Donated	3,107	1,655	0	0	645	0	28	20	5,455
Government Granted	0	132	0	0	294	0	0	0	426
At 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479
Asset financing :									
Owned	78,456	610,791	2,615	23,203	64,000	76	20,752	3,115	803,008
Held on finance lease	0	0	0	0	0	0	504	0	504
On-SoFP PFI contracts	0	6,711	0	0	256	0	0	0	6,967
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2022	78,456	617,502	2,615	23,203	64,256	76	21,256	3,115	810,479

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000
Freehold	691,251
Long Leasehold	7,179
Short Leasehold	143
	698,573

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account. **0**

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the Royal Institute of Chartered Surveyors Valuation Standards, 6th Edition . LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

i) Donated Assets
Assets totalling £272k during the year were purchased via Charitable Funds donations and contributions from ABUHB R&D income, Nevill Hall Creche and Sparkle.

ii) Valuations
The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2022-23 indexation has been applied to the land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 006 issued by Welsh Government on 29th March 2023. No indexation has been applied to equipment.

In addition, in 2022-23 there have been separate revaluations for four assets under construction coming into use. The most significant of these is the opening of the Same Day Emergency Care Unit (SDEC) at Grange University Hospital, with the others relating to the Children's A&E extension at GUH, Ante Natal relocation at Nevill Hall Hospital, and Refurbishment of Ward B6 at Royal Gwent Hospital.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
The Health Board is required to assess whether it owns any surplus assets which have no sale restrictions and plans for future use to comply with IFRS 13. No such assets were identified in 2022-23, therefore no write downs are applicable.

vi) The LHB does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or sold in the period.
There are no assets held for sale or sold in the period.

Reinforced Autoclaved Aerated Concrete (RAAC)
The detailed extent and condition of the NHS Wales organisations identified as having Reinforced Autoclaved Aerated Concrete (RAAC), has yet to be completed. Thus to make an informed assessment to determine the remaining life assessment of the buildings further work is required. This work is being undertaken at present across all of the NHS Estate (which will hopefully be completed by late summer 2023) which will enable such an assessment to be made for the 23-24 financial year

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2022	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2023	0	0	0	0	0	**0**
Balance brought forward 1 April 2021	337	782	86	0	0	**1,205**
Plus assets classified as held for sale in the year	0	0	91	0	0	**91**
Revaluation	0	0	0	0	0	**0**
Less assets sold in the year	(337)	(782)	(177)	0	0	**(1,296)**
Add reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward 31 March 2022	0	0	0	0	0	**0**

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, six are significant in their own right:
- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £1,468k
- Brynmawr Medical Centre held under Land & Buildings NBV at 31 March 2023 £2,839k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2023 £2,732 k
- Blaenavon Primary Care Resource Centre (managed GP practice lease) held under Land & Buildings NBV at 31 March 2023 £1,242k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2023 £2,709k

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	0
Lease prepayments in relation to RoU Assets	0	266	0	0	157	18	0	0	441
Transfer of Finance Leases from PPE Note	0	424	0	0	0	0	517	0	941
Operating Leases Transitioning	813	15,071	0	0	6,853	342	1,143	0	24,222
Cost or valuation at 1 April	**813**	**15,761**	**0**	**0**	**7,010**	**360**	**1,660**	**0**	**25,604**
Additions	0	1,471	0	0	1,463	199	0	0	3,133
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	-91	0	0	0	0	0	0	-91
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	-287	0	0	0	0	0	0	-287
At 31 March	**813**	**16,854**	**0**	**0**	**8,473**	**559**	**1,660**	**0**	**28,359**
Depreciation at 31 March	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases from PPE Note	0	108	0	0	0	0	13	0	121
Operating Leases Transitioning	0	0	0	0	0	0	0	0	0
Depreciation at 1 April	**0**	**108**	**0**	**0**	**0**	**0**	**13**	**0**	**121**
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	-108	0	0	0	0	0	0	-108
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	98	2,118	0	0	1,519	269	475	0	4,479
At 31 March	**98**	**2,118**	**0**	**0**	**1,519**	**269**	**488**	**0**	**4,492**
Net book value at 1 April	**813**	**15,653**	**0**	**0**	**7,010**	**360**	**1,647**	**0**	**25,483**
Net book value at 31 March	**715**	**14,736**	**0**	**0**	**6,954**	**290**	**1,172**	**0**	**23,867**

RoU Asset Total Value Split by Lessor Lessor	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercorn Leases	704	314	0	0	0	0	0	0	1,018
Other Public Sector Market Value Leases	11	1,875	0	0	0	0	0	0	1,886
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	12,547	0	0	6,954	290	1,172	0	20,963
Total	715	14,736	0	0	6,954	290	1,172	0	23,867

11.3 Right of Use Assets continued

Quantitative disclosures

Maturity analysis	
Contractual undiscounted cash flows relating to lease liabilities	**£000**
Less than 1 year	4235
2-5 years	10489
> 5 years	8948
Total	**23672**

Lease Liabilities (net of irrecoverable VAT)	**£000**
Current	4008
Non-Current	18464
Total	**22472**

Amounts Recognised in Statement of Comprehensive Net Expenditure	**£000**
Depreciation	4479
Impairment	0
Variable lease payments not included in lease liabilities - Interest expense	232
Sub-leasing income	-2
Expense related to short-term leases	552
Expense related to low-value asset leases (excluding short-term leases)	858

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)	**£000**
Interest expense	232
Repayments of principal on leases	4577
Total	**4809**

The LHB leases land, buildings and equipment where required to deliver core services.

Where an extension option exists within a lease, the LHB has assessed on an individual contract basis and reflected the extension period within the reported liabilities where it is reasonably certain that the option will be exercised.

12. Intangible non-current assets

2022-23

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2022	1,838	0	7,535	0	0	0	9,373
Revaluation	0	0	0	0	0	0	0
Reclassifications	1,718	0	0	0	0	0	1,718
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	66	0	955	0	0	0	1,021
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(75)	0	(718)	0	0	0	(793)
Gross cost at 31 March 2023	3,547	0	7,772	0	0	0	11,319
Amortisation at 1 April 2022	714	0	3,448	0	0	0	4,162
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	490	0	2,369	0	0	0	2,859
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(75)	0	(718)	0	0	0	(793)
Amortisation at 31 March 2023	1,129	0	5,099	0	0	0	6,228
Net book value at 1 April 2022	1,124	0	4,087	0	0	0	5,211
Net book value at 31 March 2023	2,418	0	2,673	0	0	0	5,091
NBV at 31 March 2023							
Purchased	2,418	0	2,673	0	0	0	5,091
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2023	2,418	0	2,673	0	0	0	5,091

12. Intangible non-current assets
2021-22

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	**Total**
	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 31 March bf	0	0	0	0	0	0	0
NHS Wales Transfers	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0
Cost or valuation at 1 April 2021	2,443	0	7,161	0	0	0	9,604
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	59	0	1,106	0	0	0	1,165
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(664)	0	(732)	0	0	0	(1,396)
Gross cost at 31 March 2022	1,838	0	7,535	0	0	0	9,373
Amortisation at 1 April 2021	970	0	2,039	0	0	0	3,009
Revaluation	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	408	0	2,109	0	0	0	2,517
Reclassified as held for sale	0	0	0	0	0	0	0
Transfers	0	0	0	0	0	0	0
Disposals	(664)	0	(700)	0	0	0	(1,364)
Amortisation at 31 March 2022	714	0	3,448	0	0	0	4,162
Net book value at 1 April 2021	1,473	0	5,122	0	0	0	6,595
Net book value at 31 March 2022	1,124	0	4,087	0	0	0	5,211
NBV at 31 March 2022							
Purchased	1,124	0	4,087	0	0	0	5,211
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2022	1,124	0	4,087	0	0	0	5,211

Additional Disclosures re Intangible Assets

Disclosures:
i) Donated Assets
ABUHB has not received any donated intangible assets during the year.

ii) Recognition
Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives
The useful economic life of Intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of LHB professionals and Finance staff.

13 . Impairments

	2022-23 Property, plant & equipment £000	**2022-23 Right of Use Assets £000**	**2022-23 Intangible assets £000**	2021-22 Property, plant & equipment £000	2021-22 Right of Use Assets £000	2021-22 Intangible assets £000
Impairments arising from :						
Loss or damage from normal operations	**0**	**0**	**0**	0		0
Abandonment in the course of construction	**0**	**0**	**0**	171		0
Over specification of assets (Gold Plating)	**0**	**0**	**0**	0		0
Loss as a result of a catastrophe	**0**	**0**	**0**	0		0
Unforeseen obsolescence	**0**	**0**	**0**	0		0
Changes in market price	**0**	**0**	**0**	0		0
Others (specify)	**10,557**	**0**	**0**	7,103		0
Reversal of Impairments	**(26,479)**	**0**	**0**	(19,893)		0
Total of all impairments	**(15,922)**	**0**	**0**	(12,619)		0
Analysis of impairments charged to reserves in year :						
Charged to the Statement of Comprehensive Net Expenditure	**(19,470)**	**0**	**0**	(12,619)		0
Charged to Revaluation Reserve	**3,548**	**0**	**0**	0		0
Total	**(15,922)**	**0**	**0**	(12,619)		0

2022-23	Impairment amount £000	Reason for impairment £000	Nature of Asset £000	Valuation basis £000	Charge to SoCNE £000	Charge to reserve £000
Quinquennial District Valuer Revaluation Exercise	3,760	DV Valuation	Operational	Fair Value	2,214	1,546
Indexation - Land	2,397	Indexation Loss	Operational	Fair Value	395	2,002
SDEC, Grange University Hospital	3,429	Assets Valued on Coming Into Use	Operational	Fair Value	3,429	0
SRU Enabling Ante Natal, NHH	454	Assets Valued on Coming Into Use	Operational	Fair Value	454	0
CAEU, Grange University Hospital	379	Assets Valued on Coming Into Use	Operational	Fair Value	379	0
Ward B6, RGH	138	Assets Valued on Coming Into Use	Operational	Fair Value	138	0
Total Impairment	10557				7009	3548
Reversal of Impairments						
Quinquennial District Valuer Revaluation Exercise	(11,793)	DV Valuation - Reversal of impairment in previous years	Operational	Indexation	(11,793)	0
Grange University Hospital	(12,471)	Indexation - reversal of impairment in previous years	Operational	Indexation	(12,471)	0
Ysbyty Aneurin Bevan	(1,789)	Indexation - reversal of impairment in previous years	Operational	Indexation	(1,789)	0
St Cadocs	(143)	Indexation - reversal of impairment in previous years	Operational	Indexation	(143)	0
Llanfrechfa Grange	(104)	Indexation - reversal of impairment in previous years	Operational	Indexation	(104)	0
Royal Gwent	(70)	Indexation - reversal of impairment in previous years	Operational	Indexation	(70)	0
Nevill Hall	(62)	Indexation - reversal of impairment in previous years	Operational	Indexation	(62)	0
Various Community Sites	(47)	Indexation - reversal of impairment in previous years	Operational	Indexation	(47)	0
Total Reversal of Impairments	-26479				(26,479)	0
Net credit to SoCNE	-15922				-19470	3548

14.1 Inventories

	31 March 2023	31 March 2022
	£000	£000
Drugs	2,819	2,905
Consumables	6,471	5,561
Energy	286	260
Work in progress	0	0
Other	0	0
Total	9,576	8,726
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2023	31 March 2022
	£000	£000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	0	0

15. Trade and other Receivables

Current	**31 March 2023 £000**	31 March 2022 £000
Welsh Government	**1,517**	6,903
WHSSC / EASC	**1,019**	3,038
Welsh Health Boards	**3,175**	1,552
Welsh NHS Trusts	**4,309**	6,114
Welsh Special Health Authorities	**1,010**	455
Non - Welsh Trusts	**66**	178
Other NHS	**213**	0
2019-20 Scheme Pays - Welsh Government Reimbursement	**141**	756
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	**109,290**	84,862
NHS Wales Primary Sector FLS Reimbursement	**111**	2
NHS Wales Redress	**587**	475
Other	**0**	0
Local Authorities	**9,756**	8,159
Capital debtors - Tangible	**0**	0
Capital debtors - Intangible	**0**	0
Other debtors	**16,714**	15,653
Provision for irrecoverable debts	**(1,763)**	(1,870)
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**6,017**	7,497
Other accrued income	**0**	0
Sub total	**152,162**	133,774
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Non - Welsh Trusts	**0**	0
Other NHS	**0**	0
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	**76,333**	124,435
NHS Wales Primary Sector FLS Reimbursement	**2**	57
NHS Wales Redress	**0**	0
Other	**0**	0
Local Authorities	**0**	0
Capital debtors - Tangible	**0**	0
Capital debtors - Intangible	**0**	0
Other debtors	**1,131**	1,205
Provision for irrecoverable debts	**0**	0
Pension Prepayments NHS Pensions	**0**	0
Pension Prepayments NEST	**0**	0
Other prepayments	**0**	0
Other accrued income	**0**	0
Sub total	**77,466**	125,697
Total	**229,628**	259,471

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2023 £000	31 March 2022 £000
By up to three months	**2,415**	1,365
By three to six months	**360**	409
By more than six months	**1,331**	1,289
	4,106	3,063

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	**(1,870)**	(1,951)
Transfer to other NHS Wales body	**0**	0
Amount written off during the year	**0**	17
Amount recovered during the year	**3**	0
(Increase) / decrease in receivables impaired	**119**	62
Bad debts recovered during year	**(15)**	2
Balance at 31 March	**(1,763)**	(1,870)

In determining whether a debt is impaired consideration is given to the age of the debt and the results of actions taken to recover the debt, including reference to credit agencies.

Receivables VAT

Trade receivables	**1,899**	2,674
Other	**92**	314
Total	**1,991**	2,988

16. Other Financial Assets

	Current		Non-current	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**34**	33	**487**	521
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**24**		**239**	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCNE	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**58**	**33**	**726**	**521**

17. Cash and cash equivalents

	2022-23 £000	2021-22 £000
Balance at 1 April	**1,720**	1,821
Net change in cash and cash equivalent balances	**2,984**	(101)
Balance at 31 March	**4,704**	1,720
Made up of:		
Cash held at GBS	**4,681**	1,698
Commercial banks	**0**	0
Cash in hand	**23**	22
Cash and cash equivalents as in Statement of Financial Position	**4,704**	1,720
Bank overdraft - GBS	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**4,704**	1,720

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities a re;

PFI liabilities £947k

The movement relates to cash, no comparative information is required by IAS 7 in 2022-23.

18. Trade and other payables

Current	**31 March 2023**	31 March 2022
	£000	£000
Welsh Government	**44**	75
WHSSC / EASC	**3,125**	4,487
Welsh Health Boards	**3,461**	2,646
Welsh NHS Trusts	**6,088**	4,338
Welsh Special Health Authorities	**80**	216
Other NHS	**4,559**	3,725
Taxation and social security payable / refunds	**17,761**	5,694
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**58,923**	70,123
Local Authorities	**27,191**	15,293
Capital payables- Tangible	**7,189**	9,701
Capital payables- Intangible	**206**	1,117
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**4,008**	
Obligations under finance leases, HP contracts		50
Imputed finance lease element of on SoFP PFI contracts	**1,036**	947
Pensions: staff	**9,797**	9,683
Non NHS Accruals	**88,638**	103,786
Deferred Income:		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**(9,982)**	(8,591)
Sub Total	**222,124**	223,290
Non-current		
Welsh Government	**0**	0
WHSSC / EASC	**0**	0
Welsh Health Boards	**0**	0
Welsh NHS Trusts	**0**	0
Welsh Special Health Authorities	**0**	0
Other NHS	**0**	0
Taxation and social security payable / refunds	**0**	0
Refunds of taxation by HMRC	**0**	0
VAT payable to HMRC	**0**	0
Other taxes payable to HMRC	**0**	0
NI contributions payable to HMRC	**0**	0
Non-NHS payables - Revenue	**0**	0
Local Authorities	**0**	0
Capital payables- Tangible	**0**	0
Capital payables- Intangible	**0**	0
Overdraft	**0**	0
Rentals due under operating leases	**0**	0
RoU Lease Liability	**18,464**	
Obligations under finance leases, HP contracts		446
Imputed finance lease element of on SoFP PFI contracts	**2,228**	3,263
Pensions: staff	**0**	0
Non NHS Accruals	**0**	0
Deferred Income :		
Deferred Income brought forward	**0**	0
Deferred Income Additions	**0**	0
Transfer to / from current/non current deferred income	**0**	0
Released to SoCNE	**0**	0
Other creditors	**0**	0
PFI assets –deferred credits	**0**	0
Payments on account	**0**	0
Sub Total	**20,692**	3,709
Total	**242,816**	226,999

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangible figure includes balances that have been agreed with other NHS Wales bodies, as part of the Agreement of Balances process, totalling £79k (£11k with Welsh Health Boards & £68k with Welsh NHS Trusts).

The impact of the implementation of IFRS 16 in 2022/23 has resulted in a reclassification of leases, with £22,472k now being classified as RoU leases, that would previously have been classified as operating leases or finance leases.

RoU Lease Liability Transitioning & Transferring	**£000**
RoU liability as at 31 March 2022	**0**
Transfer of Finance Leases from PPE Note	**820**
Operating Leases Transitioning	**24,222**
RoU Lease liability as at 1 April 2022	**25,042**

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	31 March 2023 £000	31 March 2022 £000
Between one and two years	4,352	1,086
Between two and five years	6,585	1,045
In five years or more	9,755	1,578
Sub-total	20,692	3,709

19. Other financial liabilities

	Current		Non-current	
Financial liabilities	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Financial Guarantees:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Derivatives at fair value through SoCNE	0	0	0	0
Other:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Total	**0**	0	**0**	0

20. Provisions

	At 1 April 2022	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-									
Secondary care	56,805	(16,033)	(8,975)	52,699	42,660	(11,816)	(34,462)	0	80,878
Primary care	41	0	0	0	40	(2)	0	0	79
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	331
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	599	0	0	0	786	(598)	(308)	0	479
All other losses and special payments	0	0	0	0	34	(34)	0	0	0
Defence legal fees and other administration	2,239	0	0	327	1,953	(1,334)	(879)		2,306
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	395			684	50	(392)	(415)	63	385
2019-20 Scheme Pays - Reimbursement	11			0	0	(5)	0	0	6
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	449	0	0	0	449
Other	3,067		0	0	(13)	(5)	(682)		2,367
Total	63,283	(16,033)	(9,092)	53,710	46,475	(14,334)	(36,792)	63	87,280
Non Current									
Clinical negligence:-									
Secondary care	123,659	0	0	(52,699)	5,380	(696)	(1,117)	0	74,527
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,262	0	0	0	36	(262)	(321)	55	2,770
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,042	0	0	(327)	144	(50)	(34)		775
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	3,311			(684)	0	0	0	0	2,627
2019-20 Scheme Pays - Reimbursement	745			0	0	(3)	(606)	0	136
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	0	0	0	0	0
Other	405		0	0	137	(97)	(94)		351
Total	132,424	0	0	(53,710)	5,697	(1,108)	(2,172)	55	81,186
TOTAL									
Clinical negligence:-									
Secondary care	180,464	(16,033)	(8,975)	0	48,040	(12,512)	(35,579)	0	155,405
Primary care	41	0	0	0	40	(2)	0	0	79
Redress Secondary care	126	0	(117)	0	516	(148)	(46)	0	331
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,861	0	0	0	822	(860)	(629)	55	3,249
All other losses and special payments	0	0	0	0	34	(34)	0	0	0
Defence legal fees and other administration	3,281	0	0	0	2,097	(1,384)	(913)		3,081
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	3,706			0	50	(392)	(415)	63	3,012
2019-20 Scheme Pays - Reimbursement	756			0	0	(8)	(606)	0	142
Restructuring	0			0	0	0	0	0	0
RoU Asset Dilapidations CAME	0			0	0	0	0	0	0
Other Capital Provisions	0			0	449	0	0	0	449
Other	3,472		0	0	124	(102)	(776)		2,718
Total	195,707	(16,033)	(9,092)	0	52,172	(15,442)	(38,964)	118	168,466

Expected timing of cash flows:

	In year to 31 March 2024	Between 1 April 2024 31 March 2028	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	80,878	74,527	0	155,405
Primary care	79	0	0	79
Redress Secondary care	331	0	0	331
Redress Primary care	0	0	0	0
Personal injury	479	1,323	1,447	3,249
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	2,306	775	0	3,081
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	385	2,627	0	3,012
2019-20 Scheme Pays - Reimbursement	6	17	119	142
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	449	0	0	449
Other	2,367	351	0	2,718
Total	87,280	79,620	1,566	168,466

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2023/24 it will receive £82,013,376 and in 2024/25 and beyond £74,980,511 from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £426,553. The estimation method used to calculate the provision for 2022/23 is consistent with the methodology used in 2021/22. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision.

The total Health Board provision also includes an amount of £340,184 which relates to 50 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

- clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff have until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provsion of £141,451 (as notified by Welsh Government) within these accounts.

20. Provisions (continued)

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Clinical negligence:-									
Secondary care	40,393	(7,745)	(9,204)	26,472	25,378	(6,325)	(12,164)	0	**56,805**
Primary care	0	0	0	0	84	(43)	0	0	**41**
Redress Secondary care	312	0	0	0	252	(371)	(67)	0	**126**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	117	0	(195)	0	1,261	(555)	(29)	0	**599**
All other losses and special payments	0	0	0	0	665	(665)	0	0	**0**
Defence legal fees and other administration	1,857	0	0	672	1,870	(1,271)	(889)		**2,239**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	412			317	333	(404)	(210)	(53)	**395**
2019-20 Scheme Pays - Reimbursement	0			0	11	0	0	0	**11**
Restructuring	0			0	0	0	0	0	**0**
Other	2,908		0	0	1,273	(275)	(839)		**3,067**
Total	**45,999**	**(7,745)**	**(9,399)**	**27,461**	**31,127**	**(9,909)**	**(14,198)**	**(53)**	**63,283**
Non Current									
Clinical negligence:-									
Secondary care	116,068	0	(185)	(26,472)	49,738	(140)	(15,350)	0	**123,659**
Primary care	0	0	0	0	0	0	0	0	**0**
Redress Secondary care	0	0	0	0	0	0	0	0	**0**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,353	0	0	0	209	(256)	0	(44)	**3,262**
All other losses and special payments	0	0	0	0	0	0	0	0	**0**
Defence legal fees and other administration	1,525	0	0	(672)	303	(89)	(25)		**1,042**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	3,628			(317)	0	0	0	0	**3,311**
2019-20 Scheme Pays - Reimbursement	0			0	745	0	0	0	**745**
Restructuring	0			0	0	0	0	0	**0**
Other	368		0	0	151	(80)	(34)		**405**
Total	**124,942**	**0**	**(185)**	**(27,461)**	**51,146**	**(565)**	**(15,409)**	**(44)**	**132,424**
TOTAL									
Clinical negligence:-									
Secondary care	156,461	(7,745)	(9,389)	0	75,116	(6,465)	(27,514)	0	**180,464**
Primary care	0	0	0	0	84	(43)	0	0	**41**
Redress Secondary care	312	0	0	0	252	(371)	(67)	0	**126**
Redress Primary care	0	0	0	0	0	0	0	0	**0**
Personal injury	3,470	0	(195)	0	1,470	(811)	(29)	(44)	**3,861**
All other losses and special payments	0	0	0	0	665	(665)	0	0	**0**
Defence legal fees and other administration	3,382	0	0	0	2,173	(1,360)	(914)		**3,281**
Pensions relating to former directors	0			0	0	0	0	0	**0**
Pensions relating to other staff	4,040			0	333	(404)	(210)	(53)	**3,706**
2019-20 Scheme Pays - Reimbursement	0			0	756	0	0	0	**756**
Restructuring	0			0	0	0	0	0	**0**
Other	3,276		0	0	1,424	(355)	(873)		**3,472**
Total	**170,941**	**(7,745)**	**(9,584)**	**0**	**82,273**	**(10,474)**	**(29,607)**	**(97)**	**195,707**

The expected timing of cash flows are based on best available information; but they could change on the basis of individual c ase changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2022/23 it will receive £57,649,915 and in 2023/24 and beyond £124,434,996 from the Welsh Risk Pool in respect of clinical negligence an d personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £494,632. The estimation method used to calculate the provision for 2021/22 is consistent with the methodology used in 2020/21. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and a provision for potential pension costs know as 'final pay control'.

The total Health Board provision also includes an amount of £126,227 which relates to 20 Redress cases where offers have been made to the families but not yet accepted or breach and causation have been proven.

21. Contingencies

21.1 Contingent liabilities

	2022-23 £'000	2021-22 £'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	337,156	408,594
Primary care	1,251	181
Redress Secondary care	0	62
Redress Primary care	3	0
Doubtful debts	0	0
Equal Pay costs	0	0
Defence costs	4,625	5,453
Continuing Health Care costs	1,379	718
Other	0	0
Total value of disputed claims	344,414	415,008
Amounts (recovered) in the event of claims being successful	(339,412)	(410,445)
Net contingent liability	5,002	4,563

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims c annot be determined and no provision has been made for them. The value of legal claims has decreased by £70m from the value of legal claims in 2021/22, while the number of claims has decreased from 272 in 2021/22 to 224 in 2022/23.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the N HS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties
The Health Board continues to make good progress in reviewing the outstanding claims for reimbursement of retrospective care payments (IRPs) during 2022/23. As a consequence there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.427m provision made for probable continuing care costs relating to 52 outstanding phase 1 to 8 claims received by 31st March 2023. This compares with the 2021/22 provision of £0.495m and 52 outstanding phase 1 to 7 claims.

Note 21.1 also sets out the £1.379m contingent liability for possible additional continuing care costs relating to those clai ms if they are all settled and in full, comparing adversely with the £0.718m reported for 2021/22.

There are still 10 new (Phase 8) claims, which have been received whereby the assessment process remains incomplete, as we ar e still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary team and for those reasons can take many months. At this stage, the HB does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to the HB, which cannot be quantified at this time.

Reinforced Autoclaved Aerated Concrete (RAAC)
An issue has been identified with RAAC within the Health Board Estate and investigative work and surveys are ongoing to ascer tain the extent and financial impact of any remedial work. Given the uncertainties surrounding the timing of the conclusion to the investigative work and its findings to be known, it is not possible to estimate the financial effect.

21.2 Remote Contingent liabilities

	2022-23 £000	2021-22 £000
Guarantees	0	0
Indemnities	33,808	8,827
Letters of Comfort	0	0
Total	**33,808**	**8,827**

The remote contingent liabilities cost consists of 11 medical negligence cases in 2022/23 (2 medical negligence cases and 1 personal injury case in 2021/22). Should these cases progress the majority of the costs incurred, in excess of £25K per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2022-23 £000	2021-22 £000
	0	0
	0	0
	0	0
Total	**0**	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2022-23 £000	2021-22 £000
Property, plant and equipment	54,039	11,282
Right of Use Assets	0	
Intangible assets	689	0
Total	**54,728**	11,282

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2023	
	Number	£
Clinical negligence	103	22,051,355
Personal injury	45	1,055,159
All other losses and special payments	64	639,863
Total	212	23,746,377

Analysis of cases in excess of £300,000

	Case Type		In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
			Number	£	Number	£
Cases in excess of £300,000:						
	Clinical Negligence	00RVFMN0045	260,344		00RVFMN0045	460,030
	Personal injury	04RVFPI0038	28,064		04RVFPI0038	493,882
	Clinical Negligence	10RVFMN0058	3,490,100		10RVFMN0058	3,950,000
	Clinical Negligence	12RVFMN0036	375,000		12RVFMN0036	375,000
	Clinical Negligence	12RVFMN0069	110,585		12RVFMN0069	1,360,585
	Clinical Negligence	14RVFMN0084	0		14RVFMN0084	752,288
	Clinical Negligence	14RVFMN0114	445,000		14RVFMN0114	4,186,563
	Clinical Negligence	14RVFMN0252	25,000		14RVFMN0252	1,710,995
	Clinical Negligence	15RVFMN0058	270,000		15RVFMN0058	470,000
	Clinical Negligence	15RVFMN0059	110,600		15RVFMN0059	350,600
	Clinical Negligence	15RVFMN0100	550,000		15RVFMN0100	550,000
	Clinical Negligence	16RVFMN0122	2,230,000		16RVFMN0122	2,230,000
	Clinical Negligence	16RVFMN0131	0		16RVFMN0131	300,781
	Clinical Negligence	16RVFMN0141	480,576		16RVFMN0141	480,576
	Clinical Negligence	16RVFMN0168	2,095,000		16RVFMN0168	2,135,000
	Clinical Negligence	16RVFMN0206	390,000		16RVFMN0206	885,000
	Clinical Negligence	16RVFMN0216	5,490,000		16RVFMN0216	6,710,000
	Clinical Negligence	16RVFMN0242	0		16RVFMN0242	632,000
	Clinical Negligence	17RVFMN0034	0		17RVFMN0034	1,130,000
	Clinical Negligence	17RVFMN0182	160,000		17RVFMN0182	1,900,000
	Clinical Negligence	17RVFMN0209	735,000		17RVFMN0209	735,000
	Clinical Negligence	18RVFMN0124	857,000		18RVFMN0124	857,000
	Personal injury	18RVFMN0016	429,177		18RVFMN0016	429,177
	Personal injury	18RVFMN0022	61,435		18RVFMN0022	431,446
	Clinical Negligence	19RVFMN0004	322,500		19RVFMN0004	400,000
	Clinical Negligence	19RVFMN0146	85,000		19RVFMN0146	570,000
	Clinical Negligence	20RVFMN0044	0		20RVFMN0044	335,000
	Clinical Negligence	20RVFMN0129	0		20RVFMN0129	350,000
	Other	20RVFEG0076	603,145		20RVFEG0076	603,145
Sub-total			**29**	**19,603,526**	**0**	**35,774,068**
All other cases			183	4,142,851	0	11,300,200
Total cases			**212**	**23,746,377**	**0**	**47,074,268**

24. Right of Use / Finance leases obligations

24.1 Obligations (as lessee)

Amounts payable under right of use asset / finance leases:	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
Land	**31 March 2023**	31 March 2022
	£000	£000
Minimum lease payments		
Within one year	**0**	0
Between one and five years	**1**	0
After five years	**12**	0
Less finance charges allocated to future periods	**(2)**	0
Minimum lease payments	**11**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**11**	0
	11	0
Present value of minimum lease payments		
Within one year	**0**	0
Between one and five years	**1**	0
After five years	**10**	0
Present value of minimum lease payments	**11**	0
Included in:		
Current borrowings	**0**	0
Non-current borrowings	**11**	0
	11	0

24.1 Right of Use / Finance leases obligations

Buildings	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000
Within one year	**2,209**	0
Between one and five years	**6,076**	0
After five years	**7,156**	0
Less finance charges allocated to future periods	**(954)**	0
Minimum lease payments	**14,487**	0
Included in:		
Current borrowings	**2,053**	0
Non-current borrowings	**12,434**	0
	14,487	0
Present value of minimum lease payments		
Within one year	**2,053**	0
Between one and five years	**5,631**	0
After five years	**6,803**	0
Present value of minimum lease payments	**14,487**	0
Included in:		
Current borrowings	**2,053**	0
Non-current borrowings	**12,434**	0
	14,487	0

Other- Non property	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000
Within one year	**2,025**	54
Between one and five years	**4,412**	217
After five years	**1,781**	248
Less finance charges allocated to future periods	**(243)**	(23)
Minimum lease payments	**7,975**	496
Included in:		
Current borrowings	**1,955**	50
Non-current borrowings	**6,020**	446
	7,975	496
Present value of minimum lease payments		
Within one year	**1,955**	50
Between one and five years	**4,281**	204
After five years	**1,739**	242
Present value of minimum lease payments	**7,975**	496
Included in:		
Current borrowings	**1,955**	50
Non-current borrowings	**6,020**	446
	7,975	496

24.2 Right of Use Assets / Finance lease receivables (as lessor)

Amounts receivable under right of use assets / finance leases:	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
	31 March 2023	31 March 2022
Gross Investment in leases	£000	£000
Within one year	26	0
Between one and five years	106	0
After five years	144	0
Less finance charges allocated to future periods	(13)	0
Minimum lease payments	263	0
Included in:		
Current financial assets	24	0
Non-current financial assets	239	0
	263	0
Present value of minimum lease payments		
Within one year	24	0
Between one and five years	98	0
After five years	141	0
Present value of minimum lease payments	263	0
Included in:		
Current financial assets	24	0
Non-current financial assets	239	0
	263	0

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

In 2021/22 the UHB had one PFI Scheme off-statement of financial position. The scheme related to the provision of replacement h eating and lighting systems within Neville Hall hospital. The scheme commenced in 2000 for a period of 25 years. Due to introduction of IFRS 16, in 2022/23 the off-statement of Financial Position PFI has been recognised as a Right of use Asset and is included in the transitioning amount at a value of £3,413k.

Commitments under off-SoFP PFI contracts	**Off-SoFP PFI contracts**	Off-SoFP PFI contracts
	31 March 2023	31 March 2022
	£000	£000
Total payments due within one year	**0**	887
Total payments due between 1 and 5 years	**0**	2,412
Total payments due thereafter	**0**	0
Total future payments in relation to PFI contracts	**0**	3,299
Total estimated capital value of off-SoFP PFI contracts	**0**	3,300

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11

	£000
Chepstow Community Hospital	**1,286**
Contract start date:	Feb-00
Contract end date:	Feb-25

Chepstow Community Hospital - a new community hospital including the provision of ancillary support services. This scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from February 2000. The obligation for the scheme is £1,045k.

	£000
Monnow Vale Health and Social Care Facility	**3,819**
Contract start date:	Mar-04
Contract end date:	Mar-36

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £1,830k.

	£000
Nevill Hall Hospital Day Surgery	**333**
Contract start date:	Sep-99
Contract end date:	Sep-24

Nevill Hall Hospital Day Surgery - a purpose built day unit including the provision of medical equipment for the unit. The PFI partner has responsibility for maintaining the building and replacing the equipment used with the unit. The scheme commenced in 1998 with unitary charge payments being made for a period of 25 years from 1999. The obligation for the scheme is £388k.

Total obligations for on-Statement of Financial Position PFI contracts due:

	On SoFP PFI Capital element 31 March 2023 £000	**On SoFP PFI Imputed interest 31 March 2023 £000**	**On SoFP PFI Service charges 31 March 2023 £000**
Total payments due within one year	**1,036**	**166**	**3,235**
Total payments due between 1 and 5 years	**1,025**	**209**	**5,592**
Total payments due thereafter	**1,203**	**157**	**6,553**
Total future payments in relation to PFI contracts	**3,264**	**532**	**15,380**

	On SoFP PFI Capital element 31 March 2022 £000	On SoFP PFI Imputed interest 31 March 2022 £000	On SoFP PFI Service charges 31 March 2022 £000
Total payments due within one year	947	239	2,670
Total payments due between 1 and 5 years	1,928	338	6,987
Total payments due thereafter	1,335	194	6,317
Total future payments in relation to PFI contracts	4,210	771	15,974

	31/03/2023 £000
Total present value of obligations for on-SoFP PFI contracts	**19,176**

25.3 Charges to expenditure	2022-23	2021-22
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	2,346	2,006
Total expense for Off Statement of Financial Position PFI contracts	0	869
The total charged in the year to expenditure in respect of PFI contracts	2,346	2,875

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	1,950	2,495
Later than five years	671	591
Total	2,621	3,086

The estimated annual payments in future years will vary from those which the LHB is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	3	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

PFI Contract	On / Off-statement of financial position
Number of PFI contracts which individually have a total commitment > £500m	0

25.5 The LHB has no Public Private Partnerships

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The LHB is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The LHB has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the LHB in undertaking its activities.

Currency risk

The LHB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The LHB has no overseas operations. The LHB therefore has low exposure to currency rate fluctuations.

Interest rate risk

LHBs are not permitted to borrow. The LHB therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the LHB's funding derives from funds voted by the Welsh Government the LHB has low exposure to credit risk.

Liquidity risk

The LHB is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The LHB is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2022-23 £000	2021-22 £000
(Increase)/decrease in inventories	(850)	1,131
(Increase)/decrease in trade and other receivables - non-current	48,026	(7,273)
(Increase)/decrease in trade and other receivables - current	(18,413)	(37,888)
Increase/(decrease) in trade and other payables - non-current	16,983	(606)
Increase/(decrease) in trade and other payables - current	(1,166)	20,846
Total	44,580	(23,790)
Adjustment for accrual movements in fixed assets - creditors	3,423	1,950
Adjustment for accrual movements in fixed assets - debtors	0	0
Other adjustments	(21,227)	888
	26,776	(20,952)

28. Other cash flow adjustments

	2022-23 £000	2021-22 £000
Depreciation	47,415	41,158
Amortisation	2,859	2,517
(Gains)/Loss on Disposal	(530)	(232)
Impairments and reversals	(19,470)	(12,619)
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	(210)	(166)
Government Grant assets received credited to revenue but non-cash	0	(22)
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	(17)	
Non-cash movements in provisions	(11,799)	35,240
Other movements	28,435	26,915
Total	46,683	92,791

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 24th July 2023; post the date the financial statements were certified by the Auditor General for Wales.

1. NHS Wales Recovery payment 2022-23

NHS Wales bodies were notified in a pay circular letter issued on 25th May 2023 by the Welsh Government, of the additional pay arrangements for employees covered by the Agenda for Change terms and conditions in Wales for 2022 - 23, which will be funded by the Welsh Government. NHS Wales bodies will make a one off non-consolidated, prorated "recovery payment" for staff employed on the Agenda for Change terms and conditions (this includes most NHS staff including nursing staff but excludes medical staff). These costs have not been recognised in the 2022-23 financial statements because the obligating event was the publication of the offer agreed with the Minister on 20 April 2023 and therefore post 31st March 2023. The costs will be accounted for in the 2023-24 Annual Accounts of NHS Wales bodies. The estimated cost is £12.725m.

30. Related Party Transactions

The Welsh Government is regarded as a related party. During the year the LHB have had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely

	2022-23		As at 31st March 2023	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	47	6,872	44	1,517
Betsi Cadwaladr University Health Board	1,260	61	727	2
Cardiff & Vale University Health Board	38,310	2,569	1,277	807
Cwm Taf University Health Board	22,402	1,821	475	306
Hywel Dda University Health Board	1,250	327	273	12
Powys Teaching Health Board	323	14,754	121	1,827
Swansea Bay University Health Board	3,992	1,018	598	222
Velindre NHS Trust	78,852	9,289	3,043	3,879
Welsh Ambulance Services NHS Trust	10,837	251	2,865	34
Public Health Wales NHS Trust	1,765	4,156	249	397
Welsh Health Specialised Services Committee	198,719	11,521	3,125	1,019
Health Education and Improvement Wales (HEIW)	43	12,720	13	780
Digital Health and Care Wales (DHCW)	6,156	1,068	67	231

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2022-23		As at 31st March 2023	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	5,186	942	2,361	350
Caerphilly County Borough Council	19,047	12,090	12,750	7,766
Monmouthshire County Council	9,681	1,120	4,445	1,071
Newport City Council	12,833	2,152	4,940	318
Torfaen County Borough Council	9,223	1,730	2,303	283

The LHB has also had significant material transactions with the following:

Aneurin Bevan Local Health Board Charitable Fund	24	1,048	31	144

A number of the LHB's Board members have interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2022-23		As at 31st March 2023	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Glyn Jones	Guys & St Thomas NHS Foundation Trust	Son is Cardiac Physiologist	3	0	4	0
	Welsh Ambulance Trust	Sister is Project Manager	10,837	251	2,865	34
	Digital Health Care Wales	Niece has an Administrative Support Role	6,156	1,068	67	231
Dr James Calvert	Royal College of Physicians	Clinical Lead of National Asthma Audit	14	5	0	2
Robert Holcombe	JW Bowkett (Electrical Installation) Ltd	Son is an Employee of the Company (Apprentice)	620	0	269	0
Philip Robson	Hospice of Valleys	Trustee	437	0	8	0
Katija Dew	Newport Live	Trustee	180	11	29	3
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	133	0	48	0
	Torfaen County Borough Council	Elected Member, Executive Portfolio holder (Education) and Deputy Leader	9,224	1,730	2,303	283
Louise Wright	Coleg QS - Training College	Director / Owner	6	0	1	0
Iwan Jones	Swansea Bay Health Board	Sister is Assistant Finance Director	3,992	1,018	598	222

31. Third Party assets

The LHB held £23,655.85 cash at bank and in hand at 31 March 2023 (31st March 2022, £25,994.53) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2023 (31st March 2022, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2023 amounted to £2.5m (£3.6m as at 31st March 2022).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit
The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is **£5,304K** which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

Gwent Wide Integrated Community Equipment Service
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£891K** for 2022/23 (£1,069K in 2021/22).

Mardy Park Rehabilitation Centre
The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is **£223K** for 2022/23 (£220K in 2021/22).

Gwent Frailty Programme
The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent , Caerphilly, Monmouthshire, Newport and Torfaen County councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£9,493K** for 2022/23 (£9,294K in 2021/22).

Continuing Healthcare - Older People in Care Homes
The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.
The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£36,563K** for 2022/23 (£31,410K in 2021/22).

Pooled Budget memorandum account for the period 1st April 2022 - 31st March 2023

Monnow Vale

	Cash	Own Contribution	Grants	Total
	£	£	£	£
Funding				
Aneurin Bevan Health Board	0	2,639,617	0	2,639,617
Monmouthshire County Council	368,347	837,095	0	1,205,442
Total Funding	**368,347**	**3,476,712**	**0**	**3,845,059**
Expenditure				
Aneurin Bevan Health Board	0	2,944,250	0	2,944,250
Monmouthshire County Council	587,559	740,549	0	1,328,107
Total Expenditure	**587,559**	**3,684,799**	**0**	**4,272,357**
Net (under)/over spend	**219,212**	**208,087**	**0**	**427,298**

33. Operating segments

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments.

34. Other Information

34.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2022 to 31 March 2023. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2022 and February 2023 alongside Health Board/Trust/SHA data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2022-23	2021-22
Statement of Comprehensive Net Expenditure for the year ended 31 March 2023	**£000**	**£000**
Expenditure on Primary Healthcare Services	**585**	581
Expenditure on Hospital and Community Health Services	**27,842**	26,334
Statement of Changes in Taxpayers' Equity For the year ended 31 March 2023		
Net operating cost for the year	**28,427**	26,915
Notional Welsh Government Funding	**28,427**	26,915
Statement of Cash Flows for year ended 31 March 2023		
Net operating cost for the financial year	**28,427**	26,915
Other cash flow adjustments	**28,427**	26,915
2.1 Revenue Resource Performance		
Revenue Resource Allocation	**28,427**	26,915
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	**585**	581
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	**78**	93
Staff costs	**27,764**	26,241
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	**28,427**	26,915
Charged to capital	**0**	0
Charged to revenue	**28,427**	26,915
18. Trade and other payables		
Current		
Pensions: staff	**0**	0
28. Other cash flow adjustments		
Other movements	**28,427**	26,915

34. Other Information

34.2 Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales bodies:

	2022-23 £000	2021-22 £000
Capital		
Capital Funding Field Hospitals		0
Capital Funding Equipment & Works	1620	7919
Capital Funding other (Specify)		0
Welsh Government Covid 19 Capital Funding	**1,620**	**7,919**
Revenue		
Stability Funding	44,413	103,562
Covid Recovery	0	24,863
Cleaning Standards	0	2,105
PPE (including All Wales Equipment via NWSSP)	2,324	5,517
Testing / TTP- Testing & Sampling - Pay & Non Pay	4,577	9,036
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	6,058	13,548
Extended Flu Vaccination / Vaccination - Extended Flu Programme	1,517	1,364
Mass Covid-19 Vaccination / Vaccination - COVID-19	8,100	10,490
Annual Leave Accrual - Increase due to Covid		1,968
Urgent & Emergency Care		1,515
Private Providers Adult Care / Support for Adult Social Care Providers		3,125
Hospices		0
Other Mental Health / Mental Health		114
Other Primary Care	2,308	1,222
Social Care		1,846
Other	1,640	412
Welsh Government Covid 19 Revenue Funding	**70,937**	**180,687**

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)1, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated :

1. Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

19 July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys,
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 436700
E-bost: abhb.enquiries@wales.nhs.uk

Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: 01633 436700
Email: abhb.enquiries@wales.nhs.uk

  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- Ensuring the regularity of any expenditure and other transactions incurred.
- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 19 July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Nicola Prygodzicz
Chief Executive and Accountable Officer
19 July 2023

Signed by:
Ann Lloyd CBE
Chair
19 July 2023

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Aneurin Bevan University Health Board

Audit year: 2022-23

Date issued: 11 July 2023

Document reference: ABUHBISA26022-23

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

We intend to issue an unqualified audit opinion. There are some issues to report to you before you consider whether to approve the Performance Report, Accountability Report and Financial Statements.

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2022-23 annual report and accounts in this report.

2 We have already discussed these issues with the Director of Finance & Procurement and the Assistant Director of Finance (Financial Systems & Services) and their team.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £17.852 million for this year's audit.

5 There are some areas of the accounts that may be of more importance to the reader and we have set a lower materiality level for these, as follows:

- remuneration report/senior pay disclosure and exit packages; and
- Related Parties.

6 We have now substantially completed this year's audit and are in the final stages of review. Some aspects of our work remain outstanding in relation to our final review of audit work.

7 We are also awaiting assurances from our external management expert who consider the work of the District Valuer.

8 We will provide an update to the Audit Committee on 18 July 2023.

9 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

Impact of revised ISA315 on this year's audit

10 Our audits of NHS accounts for the year ended 31 March 2023 have been carried out under a revised auditing standard (ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020)). The revised standard has had a significant impact this year on how auditors undertake audit risk assessments and our overall audit approach.

11 In planning our audit, we are now required to undertake more detailed and extensive risk assessment procedures to identify risks of material misstatement. The subsequent design and performance of our audit approach has been responsive to each assessed risk. **Appendices 1 and 2** summarise the audit risks we identified from our planning work and the audit work undertaken to address those risk.

12 The introduction of the revised Standard and a different audit approach has had implications for audit timetables, and the new approach has required additional time to implement. We are also conscious that there have been additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It was important that finance teams had sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process. As a result it was agreed that for 2022-23 that the revised timetable for the completion of the audit and the submission of the audited documents would be 31 July.

Exhibit 1 – impact of revised ISA315 on this year's audit

Timetable	• The Welsh Government's deadlines for health bodies to submit their 2021-22 Performance Report, Accountability Report and Financial Statements are: – the draft Financial Statements by 5 May; and – the draft Performance Report and Accountability Report by 12 May. • The Health Board met the above deadlines. • The Welsh Government's deadline for audit completion and the submission of the audited documents is 31 July. • The Auditor General for Wales is scheduled to certify his audit report on 24 July. • Thereafter, we instruct the Senedd to lay the certified Performance Report, Accountability Report and Financial Statements. The laying tends to take place for all health bodies on the same day, with the preferred date being determined by the Welsh Government to coincide with its press notice.
Audit evidence	As in previous years, we received the vast majority of audit evidence in electronic format. This year we have used Inflo Collaborate, a document sharing portal, to request and receive working papers and responses to queries to improve efficiency to the audit process. We have continued to use our Analytics Assisted Audit application during the audit for risk assessing journals.

Proposed audit opinion

13 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise, we issue an unqualified opinion. Subject to the satisfactory completion of the outstanding audit work as detailed in paragraph 6 above, we intend to issue an unqualified audit opinion on the 2022-23 financial statements, except for the regularity opinion which we intend to qualify.

14 We intend to qualify the regularity opinion because the Health Board has not achieved its first statutory financial duty to break even over a three year period. The financial position as at 31 March 2023 shows a year end deficit of £36.8 million and combined with the outturns for 2020-21 and 2021-22, a three-year deficit of £36.3 million.

15 Our proposed audit report is in **Appendix 4;** and our proposed narrative report is in **Appendix 5** which provides a more detailed explanation of the basis of the qualified regularity opinion.

16 We provide the intended opinions once you have provided us with a Letter of Representation based on that set out in **Appendix 3**. The Letter of Representation contains certain confirmations that we are required to obtain from you under auditing standards along with confirmation of other specific information you have provided to us during our audit.

Significant issues arising from the audit

Uncorrected misstatements

17 There are no misstatements identified in the accounts, which remain uncorrected.

Corrected misstatements

18 There were initially misstatements in the accounts that have now been corrected by management. However, we believe that these should be drawn to your attention, and they are set out with explanations in **Appendix 6.**

19 There are also a number of minor misstatements that have been corrected by management. However, we do not consider that they need to be drawn to your attention as part of your responsibilities over the financial reporting process. As well as a few additional disclosures, the financial corrections were minor and have not impacted on the reported deficit.

Other significant issues arising from the audit

20 In the course of the audit, we consider a number of matters relating to the accounts and report any significant issues arising to you. There were some issues arising in these areas this year as shown in **Exhibit 2**:

Exhibit 2 – significant issues arising from the audit

Significant issues arising from the audit	
Note 11 – Property, plant and equipment – existence of manually verified equipment	In response to my 2021-22 recommendation that an asset verification exercise should take place annually, the Health Board increased resources of the capital accounting team in 2022-23 to accelerate the asset tagging programme However, due to the volume of assets to be tagged, there remained a high volume of assets untagged but manually verified as existing as at 31 March 2023. Our asset existence testing focussed on untagged equipment which had a value of £83 million in Note 11 of the accounts, which had been manually verified as existing. Our testing identified one item that could not be found and therefore we were required to extend our testing sample. Our further testing identified another item that had been disposed of in 2018. Given the value of these assets we extrapolated the results. Extrapolation of this error rate to the remaining £77.5 million assets (£83 million less £5.5 million of items tested), indicates a potential misstatement of £8.2 million, which is below our materiality for the financial statements. For 2023-24, we **recommend** that the asset tagging programme is completed prior to 31 March 2024. Should not all assets be tagged by 31 March 2024, departments should be reminded to complete the manual verification process in accordance with guidance and provide evidence of asset existence such as photographic evidence.
Note 11 – Property, plant and equipment – non-verified existence of plant and equipment	As a result of the Health Board's impairment review during 2022-23, assets totalling £9.8 million were written off as having been disposed of in the year. This was either because the relevant department confirmed that the asset had been disposed of (circa £5 million)

	or the relevant department had not responded to requests for confirmation of whether the asset was still in use (circa £4.8 million). However, further information was received post-yearend, that £0.98 million of assets for which no responses had been received by 31 March were still in use and the financial statements have been amended accordingly. Work is still on going to confirm the existence of the remaining assets, in particular those for which no response had been received. However, given the total affected population of £8.8 million (this being the initial £9.8 million less the £0.98 million subsequently identified) is not material to the accounts, any items identified as still existing will be accounted for in 2023-24. For 2023-24, we **recommend** that the asset tagging programme is completed prior to 31 March 2024. Should not all assets be tagged by 31 March 2024, departments should be reminded to complete the manual verification process in accordance with guidance and provide evidence of asset existence such as photographic evidence.
Remuneration Report	Our work noted improvements in the compilation of the Remuneration Report this year. However, some amendments were required to the Remuneration Report which included: • pension benefits and bandings amended to reflect actual figures; • correct disclosure of benefits in kind; and • additional disclosure regarding secondment of senior officers to Welsh government For 2023-24, we **recommend** that the compilation of the Remuneration Report is reviewed and documented to ensure compliance with the relevant guidance from the Welsh Government.

Recommendations

21 We intend to discuss lessons learnt and recommendations arising from our audit of the financial statements at the joint post project learning session that we will hold jointly with the Finance Team. The agreed actions arising from this session and follow-up of last year's recommendations will be presented to the Audit Committee scheduled for the Autumn 2022

Follow-up of last year's significant issues arising from the audit

22 In our Audit of the Accounts Report 2021-22, we identified two significant issues arising from the audit:

- Note 11 – Property, plant and equipment - additional work required by the Health Board to provide assurance over the Gross Book Value of plant and equipment whose Net Book Value was nil**;** and
- Remuneration Report – a number of amendments were required to be made

23 Our work in these areas identified further issues which have been detailed above in **Exhibit 2** – *significant issues arising from the audit.*

Appendix 1

Significant audit risks reported in my Detailed Audit Plan 2023 and work undertaken to address those risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

The following significant financial statement risks were reported to you in my Audit Plan 2023.

Exhibit 3 – significant financial statement risks

Audit risk	Our planned response	Our audit finding
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	Our audit work did not identify any issues arising in this area.
The risk of failing to meet your first financial duty to break even over a three year period has now crystalised. The position at month 12 shows yearend surplus/deficit of £37 million. This, combined with the outturns for 2020-21 and 2021-22, predicts a three-year deficit of £36.5 million. We will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.	My audit team will focus our testing on areas of the financial statements which could contain reporting bias.	Our work in this area identified a number of issues which have been included within Exhibit 2 – significant issues arising from the audit, in the main body of this Report: • Non-existence of manually verified plant and equipment. • Disposal of non-verified plant and equipment which were

Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve a sustainable financial position in future years.		subsequently found to exist.
There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10].	My audit team will undertake detailed substantive testing to ensure expenditure transactions are appropriate. My audit team will also: • test the appropriateness of journal entries; and • evaluate the rationale for any significant transactions outside the normal course of business.	Our continuous planning no longer identified this as a significant risk and our audit approach was adapted accordingly. Our detailed audit work did not identify any issues arising in this area.

Appendix 2

Other areas of audit focus reported in my Detailed Audit Plan 2023 and work undertaken to address those risks

I set out other identified risks of material misstatement which, whilst not determined to be significant risks, I would like to bring to your attention.

The following areas of audit focus were reported to you in my Detailed Audit Plan 2023.

Exhibit 4 Other areas of audit focus

Audit risk	Our planned response	Our audit finding
There is a risk that the Gross Book Value (GBV) of assets will be materially misstated. Due to COVID, the Health Board decided not to undertake its annual asset impairment review and the process for verifying asset existence as at 31 March 2022. As part of my audit team's review of asset lives, my testing of assets recorded as having a Net Book Value (NBV) of 'nil' as at 31 March 2022 found that all of our sample tested were no longer in use and therefore the GBV of these assets was potentially materially overstated. During the audit, further work undertaken by the Finance Team to provide assurance that the GBV was not materially miss-stated resulted in a £5.1 million amendment to the financial statements and uncertainty over asset existence to a further value of £1.5 million, leading to a potential error of 25% (£6.6 million out of £25.9 million asset verification responses). Extrapolation of this error rate to the remaining £24 million assets for which no confirmations were received from departments, indicated a potential misstatement of £6 million, which was	My audit team will review the process for asset impairment review and verifying asset existence and sample test assets recorded as having a NBV of 'nil' to gain assurance that there are no material misstatements in accounting and reporting.	Our work in this area identified a number of issues which have been included within Exhibit 2 – *significant issues arising from the audit*, in the main body of this Report.

below our materiality for the financial statements. Whilst asset tagging has been implemented during 2022-23, not all assets have been tagged by 31 March 2023 and manual asset verification will need to be undertaken by departments for those areas whose assets have not been tagged.		
There is a risk that the disclosures within the Remuneration Report will be incorrect. My work identified a number of amendments to the draft 2021-22 Remuneration Report which included: • inclusion of annualised salaries for those individuals who were only in post for part of the year; and • inclusion of correct post titles. The note was both further complicated by the number of staff changes at Senior Management level and Board members. I understand that for 2022-23, the Health Board has continued to experience a significant number of changes at Senior Management level.	My audit team will review the completeness and accuracy of the Remuneration Report.	Our work in this area identified some issues which have been included within Exhibit 2 – *significant issues arising from the audit*, in the main body of this Report.
Accounting for Property, Plant and Equipment and Intangible Assets continues to be one of the most challenging areas of the accounts and there is a risk that the revaluation of the Health Board's estate is not accounted for correctly. The quinquennial revaluation of the NHS Estate took place as at 1 April 2022. To reflect the requirement to update the 1 April quinquennial revaluation figures to reflect changes to 31 March 2023 the 2022-23 tangible asset note should disclose the • quinquennial revaluation on the revaluation line: and	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert. • test the appropriateness of asset valuation bases. • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts.	Our audit work to date has not identified any issues arising in this area. However we are still awaiting assurances from our external management expert who consider the work of the District Valuer.

• subsequent indexation adjustment on the indexation line. Both being applied from the 1 April 2022. On the basis of discussions with the District Valuer, the indices should be applied: • on the 1 March 2023; • to the post quinquennial valuation figures before any depreciation applied; • depreciation then should be applied as normal; • the buildings element should be applied to specialised properties only. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	• consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	
A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23 and applies to NHS bodies from 1 April 2022. IFRS 16 provides enhanced disclosure requirements to give a basis for users of financial statements to assess the effect that leases have on the financial position, financial performance and cash flows of lessees and lessors. The 2022- 23 accounts will be the first year to include such discloses. IFRS16 will significantly change how most leased assets are accounted for as leased assets will need to be recognised as assets and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	My audit team will: • consider the completeness of the lease portfolios identified by the health board needing to be included in IFRS16 calculations. • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts. • ensure that all material disclosures have been made	Our audit work did not identify any issues arising in this area.

There is a risk that manual accruals are susceptible to management override. My audit of the 2021-22 financial statements identified misclassification of some accruals which were material and required correcting.	My audit team will: • test the appropriateness of manual accrual transactions; and • review manual accrual estimates for bias	Our audit work did not identify any issues arising in this area.
Provisions are measured at the best estimate of the expenditure required to settle present obligations. Due to the level of estimation involved in the calculation of provisions, there is a risk that provisions are susceptible to management over-ride. My audit of the 2021-22 financial statements also identified misclassification of some provision balances which were material and required correcting.	My audit team will: • test the appropriateness of provision balances; • review provision balance estimates for bias; and • test the appropriateness of provision balances classification.	Our audit work did not identify any issues arising in this area.
I audit the disclosure of related party transactions and balances to a far lower level of materiality. My audit of the 2021- 22 financial statements identified omitted disclosures, which were material and required correcting.	My audit team will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations will also include other means of testing, such as my review of Companies House records using data analytics.	Our audit work did not identify any issues arising in this area.
There are individuals within the Health Board who are currently on secondment either to other organisations or from other organisations. There is a risk that the associated secondment costs are not accounted for and disclosed correctly within the financial statements of the Health Board	My audit team will review the appropriateness of accounting arrangements and disclosures for individuals currently on secondment both inwards and outwards	My audit team has recommended that a disclosure note is added to the Remuneration Report to provide details regarding those individuals outwardly seconded to Welsh Government.

The ongoing impact if the ‘scheme pays’ initiative in respect of the NHS pension tax arrangements for clinical staff. Last year I qualified my regularity opinion, and I placed a substantive report on the statements to explain the reasons. Principally, that the expenditure relating to the scheme contravenes the requirements of Managing Welsh Public Money.	For 2022-23, whilst any transactions included in the Health Board’s financial statements strictly remain irregular, I am not classifying them as material by their nature. I consider that a further qualification of my regularity opinion would have a diminishing value, particularly against the backdrop of the Chancellor of the Exchequer abolishing the Lifetime Allowance in his March 2023 budget statement”.	Our audit work did not identify any issues arising in this area.

Appendix 3

Final Letter of Representation

Aneurin Bevan University Health Board's letter head

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

xx July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.

- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 19 July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of the Health Board
Date:	Date:

Appendix 4

Proposed Audit Report

The Certificate of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Health Board for the year ended 31 March 2023 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Health Board as at 31 March 2023 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matter described in the *Basis for Qualified Regularity Opinion* section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Health Board's financial statements because the Aneurin Bevan University Health Board has breached its resource limit by spending £36.348 million over the amount that it was authorised to spend in the three-year period 2020-2021 to 2022-2023. This spend constitutes irregular expenditure.

Further detail is set out in my Report on page xx

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Aneurin Bevan University Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and;
- the information given in the Performance and the other unaudited parts of the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report or the Annual Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;

- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Health Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Health Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the Health Board's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Health Board policies and procedures concerned with:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: posting of unusual journals, estimates, provisions, and manual accruals;
- Obtaining an understanding of Aneurin Bevan University Health Board's framework of authority as well as other legal and regulatory frameworks that the Aneurin Bevan University Health Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Aneurin Bevan University Health Board;
- Obtaining an understanding of related party relationships

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

Please see my Report on pages x to y.

Adrian Crompton
Auditor General for Wales
Date 24 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 5

The proposed Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Health Board's (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2023 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion. I have not qualified my 'true and fair' opinion in respect of any of these matters.]

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2022-23, the Health Board failed to meet the first financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Board's by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2020-21 to 2022-23.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £4,789.223 million by £36.348 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (i.e. spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Adrian Crompton

Auditor General for Wales

Date 24 July 2023

Appendix 6

Summary of Corrections Made

Following our audit the following misstatements were identified and have been corrected by management, but which we consider should be drawn to your attention due to their relevance to your responsibilities over the financial reporting process.

Exhibit 5: summary of corrections made

Value of correction	Nature of correction	Reason for correction
£1.142 million	**Statement of Changes in Taxpayer's Equity** To reclassify the movement from the Revaluation Reserve to the General Fund from the 'Impairments and reversals' to the 'Transfers between Reserves' line.	To ensure that movements in reserves are correctly classified.
£1.106 million	**Note 11.1 – Property, Plant and Equipment** Reduce the 'NHS Wales Transfers' under the 'Cost or valuation at 1 April 2022' section within the 'Plant and Machinery' category, with a corresponding increase in 'Transfer from/into other NHS bodies' in the 'As at 31 March 2023' section.	To comply with Technical Note 11 guidance issued by Welsh Government on 16 June.
£0.975 million	**Note 11.1 – Property, Plant and Equipment** Reduce the 'Disposals' under the 'Cost or valuation' section within the 'Plant and Machinery' category), with a corresponding decrease in 'Disposals' in the 'Depreciation' section.	The Health Board had written off assets as disposed which were subsequently identified as still being in use.

Various amounts and narrative	**Remuneration Report** Various amendments to the remuneration report which included: • pension benefits and bandings amended to reflect actual figures; and • correct disclosure of benefits in kind • additional disclosure regarding secondment of senior officers to Welsh government	To ensure senior managers' and directors' remuneration is correctly disclosed in accordance with relevant guidance.
Various amounts and narrative	**Other** A number of amendments to the disclosure Notes.	During the audit, we identified a number of trivial amendments and errors in the narrative which the Health Board has chosen to amend.
Various narrative	**Performance Report and Accountability Report** A number of amendments to the performance and Accountability Report, including the Annual Governance Statement.	To ensure full compliance with relevant guidance

Archwilio Cymru
Audit Wales

Audit Wales
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales
We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.